Benefits Notices

Children's Friend and Service
153 Summer Street
Providence, Rhode Island 02903
(401) 276-4300

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Health Insurance Exchange Notice
For Employers Who Offer a Health Plan to Some or All Employees

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information
When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: The Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact:

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1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.
The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer
This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

<table>
<thead>
<tr>
<th>3. Employer name</th>
<th>4. Employer Identification Number (EIN)</th>
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<td>Children's Friend and Service</td>
<td>05-0258819</td>
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<table>
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<tr>
<th>5. Employer address</th>
<th>6. Employer phone number</th>
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<tbody>
<tr>
<td>153 Summer Street</td>
<td>(401) 276-4300</td>
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<tr>
<th>7. City</th>
<th>8. State</th>
<th>9. ZIP code</th>
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<tr>
<td>Providence</td>
<td>Rhode Island</td>
<td>02903</td>
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<tr>
<th>10. Who can we contact about employee health coverage at this job?</th>
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<tr>
<td>Julie Colangeli</td>
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<table>
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<tr>
<th>11. Phone number</th>
<th>12. Email address</th>
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<tbody>
<tr>
<td>(401) 276-4300</td>
<td><a href="mailto:jcolangeli@cfsri.org">jcolangeli@cfsri.org</a></td>
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Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - [X] All employees.
- With respect to dependents:
  - [X] We do offer coverage. Eligible dependents are: Spouse, Child(ren), & Domestic Partner

[ ] If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Note: Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.
Aviso de Intercambio de Seguros de Salud

Para los empleadores que ofrecen un plan de salud a algunos o a todos los empleados

Nuevas opciones de cobertura en el mercado de seguros médicos y su cobertura médica

PARTE A: Información general

Cuando entren en vigencia las partes clave de la ley de salud en el 2014, habrá una nueva forma de adquirir seguros médicos: a través del mercado de seguros médicos. A fin de ayudarle mientras evalúa las opciones para usted y su familia, este aviso brinda información básica sobre el nuevo mercado y la cobertura médica basada en el empleo que brinda su empleador.

¿Qué es el mercado de seguros médicos?

El mercado está diseñado para ayudarle a encontrar un seguro médico que satisfaga sus necesidades y se ajuste a su presupuesto. El mercado ofrece opciones de compra en un solo sitio, para buscar y comparar opciones de seguros médicos privados. También es posible que sea elegible para un nuevo tipo de crédito tributario que reduce su prima mensual de inmediato. El periodo de inscripción para la cobertura de seguro médico a través del mercado comienza en octubre del 2013 para la cobertura que comienza el 1.º de enero del 2014.

¿Puedo ahorrar dinero en las primas del seguro médico que ofrece el mercado?

Es posible que tenga la oportunidad de ahorrar dinero y reducir su prima mensual, pero solo si su empleador no ofrece cobertura médica u ofrece una cobertura que no cumple con determinadas normas. Los ahorros en la prima por la cual puede ser elegible dependen de los ingresos de su familia.

¿La cobertura médica del empleador afecta la elegibilidad para los ahorros en la prima a través del mercado?

Sí. Si su empleador brinda cobertura médica que cumple con determinadas normas, no será elegible para un crédito tributario a través del mercado y es posible que desee inscribirse en el plan de salud de su empleador. No obstante, es posible que sea elegible para un crédito tributario que reduce la prima mensual o para una reducción en la cuota de los costos si su empleador no brinda cobertura o no brinda cobertura que cumple con determinadas normas. Si el costo del plan de su empleador que le brindaría cobertura a usted (y no, a los demás miembros de la familia) supera el 9.5 % del ingreso anual de su familia, o si la cobertura médica que brinda su empleador no cumple con la norma de "valor mínimo" establecida por la Ley del Cuidado de Salud a Bajo Precio (Affordable Care
Act o ACA, por sus siglas en inglés), es posible que sea elegible para un crédito tributario.†

Nota: Si adquiere un plan de salud a través del mercado en lugar de aceptar la cobertura médica que brinda su empleador, es posible que pierda las contribuciones (si las hay) que el empleador da para la cobertura médica que brinda. Además, las contribuciones del empleador (así como sus las contributions como empleado para la cobertura médica que brinda el empleador) a menudo se excluyen del ingreso sujeto impuesto federal y estatal. Los pagos para la cobertura médica a través del mercado se realizan después de impuestos.

¿Cómo puedo obtener más información?
Para obtener más información sobre la cobertura que brinda el empleador, consulte el resumen de la descripción del Plan o comuníquese con:
Julie Colangeli
153 Summer Street
Providence, Rhode Island 02903
(401) 276-4300
jcolangeli@cfsri.org

El mercado puede ayudarlo a evaluar sus opciones de cobertura, incluida su elegibilidad para la cobertura a través del mercado y sus costos. Visite CuidadoDeSalud.gov para obtener más información, incluida una solicitud en línea de cobertura de seguros médicos e información de contacto para un mercado de seguros médicos en su área.

PARTE B: Información sobre la cobertura médica que brinda su empleador
Esta sección incluye información sobre la cobertura médica que brinda su empleador. Si decide completar una solicitud de cobertura médica en el mercado, deberá brindar esta información. Esta información está enumerada de forma tal que coincida con la solicitud del mercado.

<table>
<thead>
<tr>
<th>3. Nombre del empleador</th>
<th>4. Número de identificación del empleador (EIN, por sus siglas en inglés)</th>
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<td>Children's Friend and Service</td>
<td>05-0258819</td>
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<tr>
<th>5. Dirección del empleador</th>
<th>6. Número de teléfono del empleador</th>
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<tbody>
<tr>
<td>153 Summer Street</td>
<td>(401) 276-4300</td>
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<tr>
<th>10. ¿Con quién podemos comunicarnos en relación con la cobertura médica del empleado en este empleo?</th>
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<tr>
<td>Julie Colangeli</td>
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<tr>
<th>11. Número de teléfono (si difiere del que figura arriba)</th>
<th>12. Dirección de correo electrónico</th>
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<tbody>
<tr>
<td>(401) 276-4300</td>
<td><a href="mailto:jcolangeli@cfsri.org">jcolangeli@cfsri.org</a></td>
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</tbody>
</table>
A continuación, encontrará información básica sobre la cobertura médica que brinda este empleador:

- Como su empleador, ofrecemos un plan de salud para los siguientes:
  - Todos los empleados.

- En cuanto a los dependientes:
  - Sí ofrecemos cobertura médica. Los dependientes elegibles son los siguientes: Spouse, Child(ren), & Domestic Partner

✔️ Si marca esta opción, esta cobertura médica cumple con la norma de valor mínimo. Asimismo, el costo de la cobertura se pretende que sea asequible para usted según los salarios de los empleados.

Nota: Incluso si el objetivo de su empleador es brindarle cobertura asequible, es posible que sea elegible para obtener un descuento en la prima a través del mercado. El mercado utilizará el ingreso de su grupo familiar, junto con otros factores, para determinar si es elegible para recibir un descuento en la prima. Si, por ejemplo, sus salarios varían de una semana a la otra (tal vez es un empleado por hora o trabaja con comisiones), si fue contratado recientemente a mitad de año o si tiene otras pérdidas de ingreso, aún así es posible que reúna los requisitos para recibir un descuento en la prima.
Notice of Patient Protections

Children’s Friend and Services Benefits Notices generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our 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 Julie Colangeli at 153 Summer Street, Providence, Rhode Island 02903, (401) 276-4300, jcolangeli@cfsri.org.

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

You do not need prior authorization from Children’s Friend and Services Benefits Notices 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 our 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 Julie Colangeli at 153 Summer Street, Providence, Rhode Island 02903, (401) 276-4300, jcolangeli@cfsri.org.
Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 30 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependent(s) lose coverage under a state Children’s Health Insurance Program (CHIP) or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of CHIP or Medicaid coverage.

If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the determination of eligibility for premium assistance from state CHIP or Medicaid.

To request special enrollment or obtain more information, contact Julie Colangeli at 153 Summer Street, Providence, Rhode Island 02903, (401) 276-4300, jcolangeli@cfsri.org.
Wellness Program Disclosure

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Julie Colangeli at 153 Summer Street, Providence, Rhode Island 02903, (401) 276-4300, jcolangeli@cfsri.org and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.
Notice of Privacy Practices

Children's Friend and Service
153 Summer Street
Providence, Rhode Island 02903
(401) 276-4300

Privacy Official:

Julie Colangeli
153 Summer Street
Providence, Rhode Island 02903
(401) 276-4300
jcolangeli@cfsri.org

Effective Date: 01/01/2021

Your Information. Your Rights. Our Responsibilities.
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.

Your Rights
You have the right to:

• Get a copy of your health and claims records
• Correct your health and claims records
• Request confidential communication
• Ask us to limit the information we share
• Get a list of those with whom we’ve shared your information
• Get a copy of this privacy notice
• Choose someone to act for you
• File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:

• Answer coverage questions from your family and friends
• Provide disaster relief
• Market our services and sell your information

Our Uses and Disclosures
We may use and share your information as we:

• Help manage the health care treatment you receive
• Run our organization
• Pay for your health services
• Administer your health plan
• Help with public health and safety issues
• Do research
• Comply with the law
• Respond to organ and tissue donation requests and work with a medical examiner or funeral director
• Address workers’ compensation, law enforcement, and other government requests
• Respond to lawsuits and legal actions

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records
• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
• We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records
• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
• We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications
• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
• We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share
• You can ask us not to use or share certain health information for treatment, payment, or our operations.
• We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information
• You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

• We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

• You can complain if you feel we have violated your rights by contacting us at:
  Julie Colangeli
  153 Summer Street
  Providence, Rhode Island 02903
  (401) 276-4300
  jcolangeli@cfsri.org

• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

• We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

• Share information with your family, close friends, or others involved in payment for your care
• Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

• Marketing purposes
• Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization
• We can use and share your information to run our organization and contact you when necessary.
• We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services
We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

• Preventing disease
• Helping with product recalls
• Reporting adverse reactions to medications
• Reporting suspected abuse, neglect, or domestic violence
• Preventing or reducing a serious threat to anyone’s health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

• We can share health information about you with organ procurement organizations.
• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers’ compensation, law enforcement, and other government requests
We can use or share health information about you:

• For workers’ compensation claims
• For law enforcement purposes or with a law enforcement official
• With health oversight agencies for activities authorized by law
• For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
• We are required by law to maintain the privacy and security of your protected health information.
• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
• We must follow the duties and privacy practices described in this notice and give you a copy of it.
• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.
Noticia de Prácticas de privacidad

Children’s Friend and Service
153 Summer Street
Providence, Rhode Island 02903
(401) 276-4300

Privacy Official:

Julie Colangeli
153 Summer Street
Providence, Rhode Island 02903
(401) 276-4300
jcolangeli@cfsri.org

Fecha de vigencia: 01/01/2021

Su información. Sus derechos. Nuestras responsabilidades.
Esta notificación describe cómo puede utilizarse y divulgarse su información médica, y cómo puede acceder usted a esta información. **Revisela con cuidado.**

Sus derechos

Usted cuenta con los siguientes derechos:

- Obtener una copia de su historial médico y de reclamos.
- Corregir en papel o en formato electrónico su historial médico.
- Solicitar comunicación confidencial.
- Pedirnos que limitemos la información que compartimos.
- Recibir una lista de aquellos con quienes hemos compartido su información.
- Obtener una copia de esta notificación de privacidad.
- Elegir a alguien que actúe en su nombre.
- Presentar una queja si considera que se violaron sus derechos de privacidad.

Sus opciones

Tiene algunas opciones con respecto a la manera en que utilizamos y compartimos información cuando:

- Respondemos las preguntas de cobertura de su familia y amigos.
- Proporcionamos alivio en caso de una catástrofe.
- Comercializamos nuestros servicios y vendemos su información.

Nuestros usos y divulgaciones

Podemos utilizar y compartir su información cuando:

- Ayudamos a administrar el tratamiento de atención médica que usted recibe.
- Dirigimos nuestra organización.
- Pagamos por sus servicios médicos.
- Administramos su plan médico.
- Ayudamos con asuntos de seguridad y salud pública.
- Realizamos investigaciones médicas.
- Cumplimos con la ley.
- Respondemos a las solicitudes de donación de órganos y tejidos y trabajamos con un médico forense o director funerario.
- Tratamos la compensación de trabajadores, el cumplimiento de la ley y otras solicitudes gubernamentales.
- Respondemos a demandas y acciones legales.
Sus derechos

Cuando se trata de su información médica, usted tiene ciertos derechos. Esta sección explica sus derechos y algunas de nuestras responsabilidades para ayudarlo.

Recibir una copia de su historial médico y de reclamos
- Puede solicitar que le muestren o le entreguen una copia de su historial médico y reclamos y otra información médica que tengamos de usted. Pregúntenos cómo hacerlo.
- Le entregaremos una copia o un resumen de su historial médico y de reclamos, generalmente dentro de 30 días de su solicitud. Podemos cobrar un cargo razonable en base al costo.

Solicitar que corrijamos el historial médico y de reclamos
- Puede solicitar que corrijamos su historial médico y de reclamos si piensa que dichos historiales son incorrectos o están incompletos. Pregúntenos cómo hacerlo.
- Podemos decir “no” a su solicitud, pero le daremos una razón por escrito dentro de 60 días.

Solicitar comunicaciones confidenciales
- Puede solicitar que nos comuniquemos con usted de una manera específica (por ejemplo, por teléfono particular o laboral) o que enviamos la correspondencia a una dirección diferente.
- Consideraremos todas las solicitudes razonables y debemos decir “sí” si nos dice que estaría en peligro si no lo hacemos.

Solicitar que limitemos lo que utilizamos o compartimos
- Puede solicitarnos que no utilicemos ni compartamos determinada información médica para el tratamiento, pago o para nuestras operaciones.
- No estamos obligados a aceptar su solicitud, y podemos decir “no” si esto afectara su atención.

Recibir una lista de aquellos con quienes hemos compartido información
- Puede solicitar una lista (informe) de las veces que hemos compartido su información médica durante los seis años previos a la fecha de su solicitud, con quién la hemos compartido y por qué.
- Incluiremos todas las divulgaciones excepto aquellas sobre el tratamiento, pago y operaciones de atención médica, y otras divulgaciones determinadas (como cualquiera de las que usted nos haya solicitado hacer). Le proporcionaremos un informe gratis por año pero cobraremos un cargo razonable en base al costo si usted solicita otro dentro de los 12 meses.

Obtener una copia de esta notificación de privacidad
- Puede solicitar una copia en papel de esta notificación en cualquier momento, incluso si acordó recibir la notificación de forma electrónica. Le proporcionaremos una copia en papel de inmediato.

Elegir a alguien para que actúe en su nombre
- Si usted le ha otorgado a alguien la representación médica o si alguien es su tutor legal, aquella persona puede ejercer sus derechos y tomar decisiones sobre su información médica.
- Nos aseguraremos de que la persona tenga esta autoridad y pueda actuar en su nombre antes de tomar cualquier medida.
Presentar una queja si considera que se violaron sus derechos

- Si cree que hemos violado sus derechos, háganselo saber en:
  Julie Colangeli
  153 Summer Street
  Providence, Rhode Island 02903
  (401) 276-4300
  jcolangeli@cfsri.org
- No tomaremos represalias en su contra por la presentación de una queja.

Sus opciones
Para determinada información médica, puede decirnos sus decisiones sobre qué compartimos.
Si tiene una preferencia clara de cómo compartimos su información en las situaciones descritas debajo, comuníquese con nosotros. Díganos qué quiere que hagamos, y seguiremos sus instrucciones.

En estos casos, tiene tanto el derecho como la opción de pedirnos que:
- Compartamos información con su familia, amigos cercanos u otras personas involucradas en el pago de su atención.
- Compartamos información en una situación de alivio en caso de una catástrofe.

Si no puede decirnos su preferencia, por ejemplo, si se encuentra inconsciente, podemos seguir adelante y compartir su información si creemos que es para beneficio propio. También podemos compartir su información cuando sea necesario para reducir una amenaza grave e inminente a la salud o seguridad.

En estos casos, nunca compartiremos su información a menos que nos entregue un permiso por escrito:
- Propósitos de mercadeo.
- Venta de su información.

Nuestros usos y divulgaciones
Por lo general, ¿cómo utilizamos o compartimos su información médica? Por lo general, utilizamos o compartimos su información médica de las siguientes maneras.

Ayudar a administrar el tratamiento de atención médica que usted recibe
- Podemos utilizar su información médica y compartirla con otros profesionales que lo estén tratando.

Ejemplo: Un médico nos envía información sobre su diagnóstico y plan de tratamiento para que podamos organizar los servicios adicionales.

Dirigir nuestra organización
- Podemos utilizar y divulgar su información para dirigir nuestra organización y comunicarnos con usted cuando sea necesario.
- No se nos permite utilizar información genética para decidir si le proveemos cobertura y el precio de dicha cobertura. Esto no se aplica a los planes de atención a largo plazo.

Ejemplo: Utilizamos su información médica para ofrecerle mejores servicios.
Pagar por sus servicios médicos
- Podemos utilizar y divulgar su información médica cuando pagamos por sus servicios médicos.

**Ejemplo:** Compartimos su información con su plan dental para coordinar el pago por su trabajo dental.

Administrar su plan
- Podemos divulgar su información médica a su patrocinador del plan médico para la administración del plan.

**Ejemplo:** Su compañía nos contrata para proveer un plan médico, y nosotros le proporcionamos a su compañía determinadas estadísticas para explicar las primas que cobramos.

¿De qué otra manera podemos utilizar o compartir su información médica?
Se nos permite o exige compartir su información de otras maneras (por lo general, de maneras que contribuyan al bien público, como la salud pública e investigaciones médicas). Tenemos que reunir muchas condiciones legales antes de poder compartir su información con dichos propósitos. Para más información, visite: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/factsheets_spanish.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/factsheets_spanish.html), disponible en español.

Ayudar con asuntos de salud pública y seguridad
- Podemos compartir su información médica en determinadas situaciones, como:
  - Prevención de enfermedades.
  - Ayuda con el retiro de productos del mercado.
  - Informe de reacciones adversas a los medicamentos.
  - Informe de sospecha de abuso, negligencia o violencia doméstica.
  - Prevención o reducción de amenaza grave hacia la salud o seguridad de alguien.

Realizar investigaciones médicas
- Podemos utilizar o compartir su información para investigación de salud.

Cumplir con la ley
- Podemos compartir su información si las leyes federales o estatales lo requieren, incluyendo compartir la información con el Departamento de Salud y Servicios Humanos si éste quiere comprobar que cumplimos con la Ley de Privacidad Federal.

Responder a las solicitudes de donación de órganos y tejidos y trabajar con un médico forense o director funerario
- Podemos compartir su información médica con las organizaciones de procuración de órganos.
- Podemos compartir información médica con un oficial de investigación forense, médico forense o director funerario cuando un individuo fallece.

Tratar la compensación de trabajadores, el cumplimiento de la ley y otras solicitudes gubernamentales
- Podemos utilizar o compartir su información médica:
  - En reclamos de compensación de trabajadores.
  - A los fines de cumplir con la ley o con un personal de las fuerzas de seguridad.
  - Con agencias de supervisión sanitaria para las actividades autorizadas por ley.
  - En el caso de funciones gubernamentales especiales, como los servicios de protección presidencial, seguridad nacional y servicios militares.
Responder a demandas y acciones legales

- Podemos compartir su información médica en respuesta a una orden administrativa o de un tribunal o en respuesta a una citación.

Nuestras responsabilidades

- Estamos obligados por ley a mantener la privacidad y seguridad de su información médica protegida.
- Le haremos saber de inmediato si ocurre un incumplimiento que pueda haber comprometido la privacidad o seguridad de su información.
- Debemos seguir los deberes y prácticas de privacidad descritas en esta notificación y entregarle una copia de la misma.
- No utilizaremos ni compartiremos su información de otra manera distinta a la aquí descrita, a menos que usted nos diga por escrito que podemos hacerlo. Si nos dice que podemos, puede cambiar de parecer en cualquier momento. Háganos saber por escrito si usted cambia de parecer.

Para mayor información, visite:

Cambios a los términos de esta notificación
Podemos modificar los términos de esta notificación, y los cambios se aplicarán a toda la información que tenemos sobre usted. La nueva notificación estará disponible según se solicite, en nuestro sitio web, y le enviaremos una copia por correo.
Women's Health and Cancer Rights Act (WHCRA) Notices

Enrollment Notice
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: $Refer to COC deductible (in-network) and Refer to COC% coinsurance (in-network) and $Refer to COC deductible (out-of-network) and Refer to COC% coinsurance (out-of-network). If you would like more information on WHCRA benefits, call your plan administrator at (401) 276-4300.

Annual Notice
Do you know that your plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at (401) 276-4300 for more information.
Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the Children's Friend and Services Benefits Notices with respect to mental health or substance use disorder benefits, please contact your plan administrator at (401) 276-4300.
Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [www.healthcare.gov](http://www.healthcare.gov).

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within **60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. Contact your State for more information on eligibility –

<table>
<thead>
<tr>
<th>ALABAMA – Medicaid</th>
<th>COLORADO – Health First Colorado (Colorado’s Medicaid Program) &amp; Child Health Plan Plus (CHP+)</th>
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</table>
| Website: [http://myalhipp.com](http://myalhipp.com)  
Phone: 1-855-692-5447 | Health First Colorado Website: [https://www.healthfirstcolorado.com](https://www.healthfirstcolorado.com)  
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711  
Health Insurance Buy-In Program (HIBI): [https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program](https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program)  
HIBI Customer Service: 1-855-692-6442 |

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<tr>
<th>ALASKA – Medicaid</th>
<th>FLORIDA – Medicaid</th>
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| The AK Health Insurance Premium Payment Program  
Website: [http://myakhipp.com](http://myakhipp.com)  
Phone: 1-866-251-4861  
Email: [CustomerService@MyAKHIPP.com](mailto:CustomerService@MyAKHIPP.com)  
Phone: 1-877-357-3268 |

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<tr>
<th>ARKANSAS – Medicaid</th>
<th>GEORGIA – Medicaid</th>
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| Website: [http://myarhipp.com](http://myarhipp.com)  
Phone: 1-855-MyARHIPP (855-692-7447) | Website: [https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp](https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp)  
Phone: 678-564-1162 ext 2131 |

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<th>CALIFORNIA – Medicaid</th>
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<tr>
<td>State</td>
<td>Program Name</td>
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<td>IOWA</td>
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<td>Private Health Insurance Premium Webpage</td>
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<td>TTY: Maine relay</td>
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<td>Phone: 1-800-442-6003</td>
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<td>Private Health Insurance Premium Webpage</td>
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<td>HIPP</td>
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<td>MONTANA</td>
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<td>NEBRASKA</td>
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<td>NEW YORK</td>
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<td>MINNESOTA</td>
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<td>NORTH CAROLINA</td>
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<td>State</td>
<td>Medicaid/CHIP Details</td>
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<tr>
<td>MISSOURI – Medicaid</td>
<td>Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a></td>
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<td>Phone: 573-751-2005</td>
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<td>OKLAHOMA – Medicaid and CHIP</td>
<td>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a></td>
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<td>Phone: 1-888-365-3742</td>
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<td>OREGON – Medicaid</td>
<td>Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a></td>
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<td><a href="http://www.oregonhealthcare.gov/index-es.html">http://www.oregonhealthcare.gov/index-es.html</a></td>
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<td>Phone: 1-800-699-9075</td>
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<tr>
<td>PENNSYLVANIA – Medicaid</td>
<td>Website: <a href="https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx">https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx</a></td>
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<td>Phone: 1-800-662-7462</td>
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<tr>
<td>RHODE ISLAND – Medicaid and CHIP</td>
<td>Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a></td>
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<td>Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)</td>
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<td>SOUTH CAROLINA – Medicaid</td>
<td>Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a></td>
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<td>Phone: 1-888-549-0820</td>
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<td>SOUTH DAKOTA – Medicaid</td>
<td>Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a></td>
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<td>Phone: 1-888-828-0059</td>
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<td>TEXAS – Medicaid</td>
<td>Website: <a href="http://gethipptexas.com/">http://gethipptexas.com/</a></td>
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<td>Phone: 1-800-440-0493</td>
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<tr>
<td>UTAH – Medicaid and CHIP</td>
<td>Medicaid Website: <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a></td>
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<td>CHIP Website: <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a></td>
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<td>Phone: 1-877-543-7669</td>
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<td>VERMONT – Medicaid</td>
<td>Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a></td>
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<td>Phone: 1-800-250-8427</td>
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<td>VIRGINIA – Medicaid and CHIP</td>
<td>Website: <a href="https://www.coverva.org/hipp/">https://www.coverva.org/hipp/</a></td>
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<td>Medicaid Phone: 1-800-432-5924</td>
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<td>CHIP Phone: 1-855-242-8282</td>
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<td>WASHINGTON – Medicaid</td>
<td>Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a></td>
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<td>Phone: 1-800-562-3022</td>
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<td>WEST VIRGINIA – Medicaid</td>
<td>Website: <a href="http://mywvhipp.com/">http://mywvhipp.com/</a></td>
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<td>Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</td>
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<td>WISCONSIN – Medicaid and CHIP</td>
<td>Website: <a href="https://www.dhs.wisconsin.gov/badgercareplus/p-100095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-100095.htm</a></td>
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<td>Phone: 1-800-362-3002</td>
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To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration
www.dol.gov/agencies/ebsa 1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services
www.cms.hhs.gov 1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

25
According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)
Asistencia con las primas bajo Medicaid y el Programa de Seguro de Salud para Menores (CHIP)

Si usted o sus hijos son elegibles para Medicaid o CHIP y usted es elegible para cobertura médica de su empleador, su estado puede tener un programa de asistencia con las primas que puede ayudar a pagar por la cobertura, utilizando fondos de sus programas Medicaid o CHIP. Si usted o sus hijos no son elegibles para Medicaid o CHIP, usted no será elegible para estos programas de asistencia con las primas, pero es probable que pueda comprar cobertura de seguro individual a través del mercado de seguros médicos.

Para obtener más información, visite www.cuidadodesalud.gov.

Si usted o sus dependientes ya están inscritos en Medicaid o CHIP y usted vive en uno de los estados enumerados a continuación, comuníquese con la oficina de Medicaid o CHIP de su estado para saber si hay asistencia con primas disponible.

Si usted o sus dependientes NO están inscritos actualmente en Medicaid o CHIP, y usted cree que usted o cualquiera de sus dependientes puede ser elegible para cualquiera de estos programas, comuníquese con la oficina de Medicaid o CHIP de su estado, llame al 1-877-KIDS NOW o visite espanol.insurekidsnow.gov/ para información sobre como presentar su solicitud. Si usted es elegible, pregunte a su estado si tiene un programa que pueda ayudarle a pagar las primas de un plan patrocinado por el empleador.

Si usted o sus dependientes son elegibles para asistencia con primas bajo Medicaid o CHIP, y también son elegibles bajo el plan de su empleador, su empleador debe permitirle inscribirse en el plan de su empleador, si usted aún no está inscrito. Esto se llama oportunidad de “inscripción especial”, y usted debe solicitar la cobertura dentro de los 60 días de haberse determinado que usted es elegible para la asistencia con las primas. Si tiene preguntas sobre la inscripción en el plan de su empleador, comuníquese con el Departamento del Trabajo electrónicamente a través de www.askebsa.dol.gov o llame al servicio telefónico gratuito 1-866-444-EBSA (3272).

Si usted vive en uno de los siguientes estados, tal vez sea elegible para asistencia para pagar las primas del plan de salud de su empleador. La siguiente es una lista de estados actualizada al 31 de enero de 2021. Comuníquese con su estado para obtener más información sobre la elegibilidad -

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<tr>
<th>ALABAMA – Medicaid</th>
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<tr>
<th>ALASKA – Medicaid</th>
<th>CALIFORNIA – Medicaid</th>
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<tr>
<td>COLORADO – Health First Colorado (Programa Medicaid de Colorado) y Child Health Plan Plus (CHP+)</td>
<td>KENTUCKY – Medicaid</td>
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<tr>
<td>Centro de atención al cliente de Health First Colorado: 1-800-221-3943/ retransmisor del estado: 711</td>
<td>Teléfono: 1-855-459-6328</td>
</tr>
<tr>
<td>CHP+: <a href="https://www.colorado.gov/pacific/hcpf/child-health-plan-plus">https://www.colorado.gov/pacific/hcpf/child-health-plan-plus</a></td>
<td>Por correo electrónico: <a href="mailto:KIHIPP_PROGRAM@ky.gov">KIHIPP_PROGRAM@ky.gov</a></td>
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<td>Programa de compra de seguro de salud (HIBI, por sus siglas en inglés): <a href="https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program">https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program</a></td>
<td>Teléfono: 1-877-524-4718</td>
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<tr>
<td>Atención al cliente de HIBI: 1-855-692-6442</td>
<td>Sitio web de Medicaid de Kentucky: <a href="https://chfs.ky.gov/Pages/spanish.aspx">https://chfs.ky.gov/Pages/spanish.aspx</a></td>
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<th>MASSACHUSETTS – Medicaid y CHIP</th>
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<td>MONTANA – Medicaid</td>
<td>Sitio web: <a href="https://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">https://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a></td>
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<td>OKLAHOMA – Medicaid y CHIP</td>
<td>Sitio web: <a href="https://www.insureoklahoma.org">https://www.insureoklahoma.org</a></td>
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<td>NEVADA – Medicaid</td>
<td>Sitio web de Medicaid: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a></td>
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<td>OREGON – Medicaid</td>
<td>Sitio web: <a href="https://healthcare.oregon.gov/Pages/index.aspx">https://healthcare.oregon.gov/Pages/index.aspx</a></td>
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<td>PENNSYLVANIA – Medicaid</td>
<td>Sitio web: <a href="https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx">https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx</a></td>
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<td>NUEVA JERSEY – Medicaid y CHIP</td>
<td>Sitio web de Medicaid: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a></td>
</tr>
<tr>
<td>RHODE ISLAND – Medicaid y CHIP</td>
<td>Sitio web: <a href="http://www.eohhs.ri.gov">http://www.eohhs.ri.gov</a></td>
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<td>CAROLINA DEL NORTE – Medicaid</td>
<td>Sitio web: <a href="https://medicaid.ncdhhs.gov">https://medicaid.ncdhhs.gov</a></td>
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<td>VIRGINIA – Medicaid y CHIP</td>
<td>Sitio web: <a href="https://www.cubrevirginia.org/hipp/">https://www.cubrevirginia.org/hipp/</a></td>
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WASHINGTON – Medicaid
Sitio web: http://www.hca.wa.gov
Teléfono: 1-800-562-3022

WISCONSIN – Medicaid y CHIP
Sitio web: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Teléfono: 1-800-362-3002

WEST VIRGINIA – Medicaid
Sitio web: http://mywvhipp.com/
Teléfono gratuito: 1-855-MyWVHIP (1-855-699-8447)

WYOMING – Medicaid
Sitio web: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Teléfono: 1-800-251-1269

Para saber si otros estados han agregado el programa de asistencia con primas desde el 31 de enero de 2021, o para obtener más información sobre derechos de inscripción especial, comuníquese con alguno de los siguientes:

Departamento del Trabajo de EE.UU.
Administración de Seguridad de Beneficios de los Empleados
1-866-444-EBSA (3272)

Departamento de Salud y Servicios Humanos de EE.UU.
Centros para Servicios de Medicare y Medicaid
www.cms.hhs.gov
1-877-267-2323, opción de menú 4, Ext. 61565

Declaración de la Ley de Reducción de Trámites

Según la Ley de Reducción de Trámites de 1995 (Ley Pública 104-13) (PRA, por sus siglas en inglés), no es obligatorio que ninguna persona responda a una recopilación de información, a menos que dicha recopilación tenga un número de control válido de la Oficina de Administración y Presupuesto (OMB, por sus siglas en inglés). El Departamento advierte que una agencia federal no puede llevar a cabo ni patrocinar una recopilación de información, a menos que la OMB la apruebe en virtud de la ley PRA y esta tenga un número de control actualmente válido de la oficina mencionada. El público no tiene la obligación de responder a una recopilación de información, a menos que esta tenga un número de control actualmente válido de la OMB. Consulte la Sección 3507 del Título 44 del Código de Estados Unidos (USC).

Además, sin perjuicio de ninguna otra disposición legal, ninguna persona quedará sujeta a sanciones por no cumplir con una recopilación de información, si dicha recopilación no tiene un número de control actualmente válido de la OMB. Consulte la Sección 3512 del Título 44 del Código de Estados Unidos (USC).

Se estima que el tiempo necesario para realizar esta recopilación de información es, en promedio, de aproximadamente siete minutos por persona. Se anima a los interesados a que envíen sus comentarios con respecto al tiempo estimado o a cualquier otro aspecto de esta recopilación de información, como sugerencias para reducir este tiempo, a la dependencia correspondiente del Ministerio de Trabajo de EE. UU., a la siguiente dirección: U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210. También pueden enviar un correo electrónico a ebssa.opr@dol.gov y hacer referencia al número de control de la OMB 1210-0137.

Número de Control de OMB 1210-0137 (vence al 31 de enero de 2023)
**Newborns' and Mothers' Health Protection Act Notice**

Group health plans and health insurance issuers generally may not, under Federal law, 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 cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). The Newborns' and Mothers' Health Protection Act requires that group health plans that offer maternity coverage pay for at least a 48-hour hospital stay following childbirth (96-hour stay in the case of Cesarean section).
Medicare Part D Creditable Coverage Notice

Important Notice from Children's Friend and Service About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Children's Friend and Service and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Children's Friend and Service has determined that the prescription drug coverage offered by the Children's Friend and Services Benefits Notices is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Children's Friend and Service coverage will not be affected. Plan participants can keep their prescription drug coverage under the group health plan if they select Medicare Part D prescription drug coverage. If they select Medicare Part D prescription drug coverage, the group health plan prescription drug coverage will coordinate with the Medicare Part D prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your current Children's Friend and Service coverage, be aware that you and your dependents will be able to get this coverage back.
When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Children's Friend and Service and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage
Contact the person listed below for further information call Julie Colangeli at (401) 276-4300. NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Children's Friend and Service changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember: Keep this Creditable Coverage notice.** If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 03/30/2021

Name of Entity/Sender: Children's Friend and Service

Contact--Position/Office: Julie Colangeli, Benefits & Wellness Specialist

Address: 153 Summer Street Providence, Rhode Island 02903

Phone Number: (401) 276-4300
Genetic Information Nondiscrimination Act (GINA) Disclosures

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic information,” as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.
**ADA Notice Regarding Wellness Program**

Children’s Friend and Services Benefits Notices is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the HRA or to participate in other medical examinations.

The information from your HRA will be used to provide you with information to help you understand your current health and potential risks. The information from your HRA may also be used to offer you services through the wellness program, such as Smoking cessation and other various programs that are offered through the United Healthcare program, Rally.. You also are encouraged to share your results or concerns with your own doctor.

However, employees who choose to participate in the wellness program will receive an incentive of Employees who complete 5 specific steps will have no health deductible for the following renewal year. for Tobacco attestation, annual medical exam, annual dental exam, health assessment and wellness activity/Rally missions.. Although you are not required to complete the HRA, only employees who do so will receive Employees who complete 5 specific steps will have no health deductible for the following renewal year..

Additional incentives, such as Gift cards, luncheons, etc., may be available for employees who participate in certain health-related activities, such as , or achieve certain health outcomes, such as . If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Julie Colangeli at 153 Summer Street, Providence, Rhode Island 02903, (401) 276-4300, jcolangeli@cfsri.org.

**Protections from Disclosure of Medical Information**

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Children's Friend and Service may use aggregate information it collects to design a program based on identified health risks in the workplace, Children's Friend and Services Benefits Notices will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only
individual(s) who will receive your personally identifiable health information is (are) Jamie Moran, Claudia Kenney and Kayla Beauvais of PGIA, Inc. dba Provider Group receive the employees' personally identifiable health information in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Julie Colangeli at 153 Summer Street, Providence, Rhode Island 02903, (401) 276-4300, jcolangeli@cfsri.org.
General Notice of COBRA Rights

(For use by single-employer group health plans)

Continuation Coverage Rights Under COBRA

Introduction
You’re getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you’re an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you’re the spouse of an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
• You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

• The parent-employee dies;
• The parent-employee’s hours of employment are reduced;
• The parent-employee’s employment ends for any reason other than his or her gross misconduct;
• The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
• The parents become divorced or legally separated; or
• The child stops being eligible for coverage under the Plan as a “dependent child.”

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

• The end of employment or reduction of hours of employment;
• Death of the employee;
• The employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

Julie Colangeli  
Benefits & Wellness Specialist  
153 Summer Street  
Providence, Rhode Island 02903  
(401) 276-4300  
jcolangeli@cfsri.org

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to
an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children’s Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don’t enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don’t enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep your Plan informed of address changes
To protect your family’s rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information
Children’s Friend and Services Benefits Notices
Julie Colangeli
153 Summer Street
Providence, Rhode Island 02903
(401) 276-4300
jcolangeli@cfsri.org
Modelo de aviso general de los derechos de la cobertura de continuación de COBRA

(para que usen los planes de salud grupales de un solo empleador)

**Derechos de la cobertura de continuación conforme a la ley COBRA**

Introducción
Le enviamos este aviso porque recientemente obtuvo la cobertura de un plan de salud grupal (el Plan). Este aviso contiene información importante acerca de su derecho a recibir la cobertura de continuación de COBRA, que es una extensión temporal de la cobertura del Plan. **Este aviso explica la cobertura de continuación de COBRA, el momento en el que usted y su familia pueden recibirla, y lo que usted puede hacer para proteger su derecho a obtenerla.** Al ser elegible para la cobertura de COBRA, también puede ser elegible para otras opciones que pueden costarle menos que la cobertura de continuación de COBRA.

El derecho a recibir la cobertura de continuación de COBRA se originó gracias a una ley federal, la Ley Ómnibus Consolidada de Reconciliación Presupuestaria (COBRA, por sus siglas en inglés) de 1985. Usted y otros familiares suyos pueden disponer de la cobertura de continuación de COBRA cuando se termine la cobertura de salud grupal. Para obtener más información acerca de sus derechos y obligaciones conforme al Plan y a la ley federal, debe revisar el resumen de la descripción del Plan o comunicarse con el administrador del Plan.

Al perder la cobertura de salud grupal, puede haber otras opciones disponibles. Por ejemplo, puede ser elegible para comprar un plan individual a través del mercado de seguros médicos. Al inscribirse en la cobertura a través del mercado de seguros médicos, puede cumplir con los requisitos para tener menores costos en las primas mensuales y gastos propios más bajos. Asimismo, puede tener derecho a un período de inscripción especial de 30 días en otro plan de salud grupal para el cual sea elegible (como un plan del cónyuge), aunque ese plan generalmente no acepte afiliados de último momento.

¿Qué es la cobertura de continuación de COBRA?
La cobertura de continuación de COBRA es la continuación de la cobertura del Plan cuando esta debería terminar debido a un evento determinado de la vida. Este acontecimiento también se conoce como “evento específico”. Los eventos específicos se incluyen más abajo en este aviso. Después de un evento específico, la cobertura de continuación de COBRA debe ofrecerse a cada persona considerada un “beneficiario que cumple con los requisitos”. Usted, su cónyuge y sus hijos dependientes podrían convertirse en beneficiarios que cumplan con los requisitos si la cobertura del Plan se pierde debido al evento específico. Según el Plan, los beneficiarios que cumplan con los requisitos y que elijan la cobertura de continuación de COBRA must payla cobertura de continuación de COBRA.

Si usted es un empleado, se convertirá en un beneficiario que cumple con los requisitos si pierde la cobertura del Plan debido a estos eventos específicos:
- sus horas de empleo se reducen; o
- su empleo termina por un motivo que no sea una falta grave de su parte.

Si usted es el cónyuge del empleado, se convertirá en un beneficiario que cumple con los requisitos si pierde la cobertura del Plan debido a estos eventos específicos:
- su cónyuge muere;
- las horas de empleo de su cónyuge se reducen;
- el empleo de su cónyuge termina por un motivo que no sea una falta grave por parte de su cónyuge;
- su cónyuge adquiere el derecho a recibir los beneficios de Medicare (Parte A, Parte B o ambas); o
- se divorcia o se separa legalmente de su cónyuge.

Sus hijos dependientes se convertirán en beneficiarios que cumplen con los requisitos si pierden la cobertura del Plan debido a estos eventos específicos:
- el empleado cubierto muere;
- las horas de empleo del empleado cubierto se reducen;
- el empleo del empleado cubierto termina por un motivo que no sea una falta grave por parte del empleado cubierto;
- el empleado cubierto adquiere el derecho a recibir los beneficios de Medicare (Parte A, Parte B o ambas);
- los padres se divorcian o se separan legalmente; o el hijo deja de ser elegible para la cobertura del Plan como “hijo dependiente”.

¿Cuándo está disponible la cobertura de continuación de COBRA?
El Plan ofrecerá la cobertura de continuación de COBRA a los beneficiarios que cumplan con los requisitos solamente después de que se le informe al administrador del Plan que ha ocurrido un evento específico. El empleador debe notificar los siguientes eventos habilitantes al administrador del Plan:
- la terminación del empleo o la reducción de las horas de empleo;
- la muerte del empleado;
- el hecho de que el empleado adquiera el derecho a recibir los beneficios de Medicare (Parte A, Parte B o ambas).

Para todos los otros eventos específicos (divorcio o separación legal del empleado y el cónyuge, o hijo dependiente que pierde la elegibilidad para la cobertura como hijo dependiente), debe avisarle al administrador del Plan en los 60 días posteriores a que se produzca el evento habilitante. Debe proporcionarle este aviso a:

Julie Colangeli
Benefits & Wellness Specialist
153 Summer Street
Providence, Rhode Island 02903
(401) 276-4300
jcolangeli@cfsri.org

¿Cómo se proporciona la cobertura de continuación de COBRA?
Después de que el administrador del Plan recibe el aviso de que se ha producido un evento específico, la cobertura de continuación de COBRA se ofrecerá a cada uno de los beneficiarios que cumplan con los requisitos. Cada beneficiario que cumpla con los requisitos tendrá su propio derecho a elegir la cobertura de continuación de COBRA. Los empleados cubiertos pueden elegir la cobertura de continuación de COBRA en nombre de su cónyuge y los padres pueden elegir la cobertura de continuación de COBRA en nombre de sus hijos.
La cobertura de continuación de COBRA es la continuación temporal de la cobertura debido a la terminación del empleo o a la reducción de las horas de trabajo, y en general dura 18 meses. Determinados eventos específicos, o un segundo evento específico durante el período inicial de cobertura, pueden permitir que el beneficiario reciba un máximo de 36 meses de cobertura.

También hay otros motivos por los cuales este período de 18 meses de la cobertura de continuación de COBRA puede prolongarse:

**Extensión por discapacidad del período de 18 meses de la cobertura de continuación de COBRA**

Si el Seguro Social determina que usted o alguien de su familia que esté cubierto por el Plan tiene una discapacidad y usted le avisa al respecto al administrador del Plan en el plazo correspondiente, usted y toda su familia pueden recibir una extensión adicional de hasta 11 meses de cobertura de continuación de COBRA, por un máximo de 29 meses. La discapacidad debe haber comenzado en algún momento antes de los 60 días de la cobertura de continuación de COBRA y debe durar al menos hasta el final del período de 18 meses de la cobertura de continuación de COBRA.

**Extensión por un segundo evento específico del período de 18 meses de la cobertura de continuación de COBRA**

Si su familia sufre otro evento específico durante los 18 meses de la cobertura de continuación de COBRA, su cónyuge y sus hijos dependientes pueden recibir hasta 18 meses adicionales de cobertura de continuación de COBRA, por un máximo de 36 meses, si se le avisa al Plan como corresponde acerca del segundo evento específico. Esta extensión puede estar disponible para el cónyuge y cualquier hijo dependiente que reciba la cobertura de continuación de COBRA en el caso de que el empleado o exempleado muera, adquiera el derecho a recibir los beneficios de Medicare (Parte A, Parte B o ambas), se divorcie o se separe legalmente, o si el hijo dependiente deja de ser elegible en el Plan como hijo dependiente. Esta extensión solo está disponible en el caso de que el segundo evento específico hubiese hecho que el cónyuge o el hijo dependiente pierda la cobertura del Plan si no se hubiese producido el primer evento específico.

¿Hay otras opciones de cobertura además de la cobertura de continuación de COBRA?

Sí. En lugar de inscribirse en la cobertura de continuación de COBRA, puede haber otras opciones de cobertura para usted y su familia a través del mercado de seguros médicos, Medicaid u otras opciones de un plan de salud grupal (por ejemplo, el plan de su cónyuge) mediante lo que se denomina un “período de inscripción especial”. Es posible que algunas de estas opciones cuesten menos que la cobertura de continuación de COBRA. Puede encontrar más información sobre muchas de estas opciones en [www.healthcare.gov](http://www.healthcare.gov).

¿Puedo inscribirme en Medicare, en caso de ser elegible, después de que finalice la cobertura de mi plan de salud colectivo?

En general, después del periodo de inscripción inicial, hay un periodo de inscripción especial de 8 meses para inscribirse en Medicare Parte A o B, que comienza cuando ocurre lo primero de lo siguiente:

- El mes posterior a la finalización del empleo.
- El mes posterior a la finalización de la cobertura del plan de salud colectivo basada en el empleo actual.

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Si elige la Ley Ómnibus Consolidada de Reconciliación Presupuestaria (COBRA) y desea inscribirse en Medicare Parte B después de que finalice su cobertura de continuación, es posible que tenga que pagar una penalidad por inscripción tardía. Si se inscribe inicialmente en Medicare Parte A o B después de elegir la cobertura de continuación COBRA, el plan puede terminar su cobertura de continuación (sin embargo, si Medicare Parte A o B entra en vigencia en la fecha de la elección de COBRA o antes de esta fecha, la cobertura de COBRA no se puede descontinuar debido al derecho a Medicare, incluso si la persona se inscribe en la otra parte de Medicare después de la fecha de la elección de la cobertura de COBRA).

Si está inscrito tanto en COBRA como en Medicare, Medicare será generalmente el pagador principal. Es posible que algunos planes “disminuyan” el monto que Medicare pagaría en caso de ser el pagador principal, incluso si usted no está inscrito.

Para obtener más información, visite www.medicare.gov/medicare-and-you

Si tiene preguntas
Las preguntas acerca de su Plan o de sus derechos a recibir la cobertura de continuación de COBRA deben enviarse al contacto o los contactos identificados abajo. Para obtener más información sobre sus derechos según la Ley de Seguridad de los Ingresos de Jubilación de los Empleados (ERISA, por sus siglas en inglés), incluida la ley COBRA, la Ley de Atención Médica (de bajo costo) y la Protección al Paciente, y otras leyes que afectan a los planes de salud grupales, comuníquese con la oficina regional o de distrito más cercana de la Administración de Seguridad de Beneficios para Empleados (EBSA, por sus siglas en inglés) del Departamento de Trabajo de Estados Unidos en su área, o visite www.dol.gov/ebsa. (Las direcciones y los números de teléfono de las oficinas regionales y de distrito de EBSA están disponibles en el sitio web de EBSA). Para obtener más información acerca del mercado de seguros médicos, visite www.HealthCare.gov.

Informe a su plan si cambia de dirección
Para proteger los derechos de su familia, informe al administrador del Plan sobre cualquier cambio en las direcciones de sus familiares. También debe conservar una copia, para su registro, de todos los avisos que le envíe al administrador del Plan.

Información de contacto del Plan
Children’s Friend and Services Benefits Notices
Julie Colangeli
153 Summer Street
Providence, Rhode Island 02903
(401) 276-4300
jcolangeli@cfsri.org
EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

Leave Entitlements
Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child’s birth or placement);
- To care for the employee’s spouse, child, or parent who has a qualifying serious health condition;
- For the employee’s own qualifying serious health condition that makes the employee unable to perform the employee’s job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee’s spouse, child, or parent.

An eligible employee who is a covered servicemember’s spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer’s normal paid leave policies.

Benefits & Protections
While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual’s FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.
Eligibility Requirements
An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee’s worksite.

*Special “hours of service” requirements apply to airline flight crew employees.

Requesting Leave
Generally, employees must give 30-days’ advance notice of the need for FMLA leave. If it is not possible to give 30-days’ notice, an employee must notify the employer as soon as possible and, generally, follow the employer’s usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary.

Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities
Once an employer becomes aware that an employee’s need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement
Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE
(1-866-487-9243) TTY: 1-877-889-5627
www.dol.gov/whd
U.S. Department of Labor | Wage and Hour Division
USERRA Notice

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right To Be Free From Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
  - Initial employment;
  - Reemployment;
  - Retention in employment;
  - Promotion; or
  - Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.
D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer’s health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

E. Enforcement

- The U.S. Department of Labor, Veterans’ Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm.

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: http://www.dol.gov/vets/programs/userra/poster.htm. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans’ Employment and Training Service, 1-866-487-2365.
Delta Dental of Rhode Island

Certificate of Coverage

Delta Dental PPO Plus PremierSM
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Delta Dental of Rhode Island
Certificate of Coverage
Delta Dental PPO Plus Premier℠

Welcome to Delta Dental of Rhode Island’s national program. This Certificate is a contract between you and Delta Dental of Rhode Island. You complete a benefits application; and, agree to pay related fees. We agree to provide benefits.

This Certificate, along with the Benefits Summary, describes the Plan. It describes the dental services covered by your Plan. It also explains how each is paid for and tells you how to use the Plan. Please contact Customer Service if you have any questions.

Our toll free Customer Service number is:

1-800-843-3582

Customer Service is open Monday through Thursday 8 a.m. to 7 p.m. (ET) and Fridays from 8 a.m. to 5 p.m. (ET). Our information line is available all day, every day.

You may also visit us online at www.deltadentalri.com.

Send claims and written correspondence to:

Delta Dental of Rhode Island
P.O. Box 1517
Providence, RI 02901-1517

This dental plan does not cover the pediatric dental services covered by the essential health benefits (EHB) benchmark plan in Rhode Island.
NOTICE OF NONDISCRIMINATION AND ACCESSIBILITY POLICY

Delta Dental of Rhode Island does not discriminate on the basis of race, color, national origin, age, disability, or sex.

We provide appropriate, free, and timely aids and services, including qualified interpreters, for individuals and information in alternate formats, when these are needed to allow people with disabilities to participate equally.

We provide language assistance services, including translated documents and oral interpretation, free of charge; and, in a timely manner when these are needed to give access to people with limited English proficiency.

If you need these services, contact us at 1-800-843-3582.

If you believe we have failed to provide these services or discriminated on the basis of race, color, national origin, disability, or sex, you can file a grievance with: Civil Rights Coordinator, Delta Dental of Rhode Island, 10 Charles Street, Providence, RI 02904, or by calling 1-800-843-3582. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically, through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington DC 20201; 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-843-3582.


繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-843-3582.

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis ed pou lang ki disponib gratis pou ou. Rele 1-800-843-3582.

ខ្មែរ (Cambodian): ប្រយ័ត្ន៖ ប្រការជាអ្នកនិយាយភាសាខ្មែរ បានជាការសម្រួលបាន អំពីការជួយប្រការ។ ចូរទូរស័ព្ទ 1-800-843-3582.

Français (French): ATTENTION : Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-800-843-3582.

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l’italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-843-3582.
Form #RI PPO Plus Premier (18)
Definitions
This document contains words used in insurance and dentistry. We have given the meaning of these words here. These terms are in italics. If you are not clear about what these words mean, please come back to this page.

- **Adverse Benefit Decision** means a decision by Delta Dental not to pay (in whole or in part) for a **covered service**, including a denial; reduction; termination; or, failure to make a payment based on a pre-existing condition exclusion; a source of injury exclusion; retroactive rescission of coverage; or, other limitation on **covered services**.

- **Allowance** means the amount we base payment on for a **covered service**. The **Allowance** for a **Participating Dentist** is the LOWEST of the:
  a) Amount set by the local Delta Dental Plan for each specific **dentist**;
  b) Maximum amount the local Delta Dental Plan will pay any **dentist** for a **covered service**; or
  c) Amount the **dentist** actually charges.

**Participating dentists** cannot charge Delta Dental patients more than the **allowance for a participating dentist**.

The **Allowance** for a **Non-participating Dentist** is:
  a) The lesser of the **dentist’s** charge or the amount determined by the local Delta Dental Plan; or
  b) The lesser of the **dentist’s** charge or an amount equal to a percent of the Delta Submitted Charges Database for that service; or
  c) The lesser of the **dentist’s** charge or an amount listed on the local Delta Dental Plan’s non-participating **dentist** fee table for that service.

- **Annual Maximum** means the most we will pay for **covered services** for a continuous 12-month period (usually a calendar year). The **annual maximum** is stated in the **Benefits Summary**.

- **Benefits Summary** is a summary description of the services covered by this dental policy; with a schedule that shows you how much we pay toward a service. If a service is not listed in the **Benefits Summary**, we will not pay for it.

- **Certificate** means this document and the **Benefits Summary**. This **Certificate** is your policy.

- **Coinsurance/Copayment** means the amount you pay for **covered services**, after the **deductible**, if any, is met. **Coinsurance** is usually shown as a percentage and **copayment** as a fixed dollar amount. The amount of **coinsurance/copayment** varies with the type of **covered services** and is shown in the **Benefits Summary**.
• **Covered Services** means those services listed in the **Benefits Summary**. All **covered services** must be **dentally necessary** and appropriate to qualify for payment.

• **Date of Service** means the date that the service was done. For services requiring more than one visit, except **orthodontics**, the **Date of Service** is the final completion date (Examples: the insertion date of a denture; the date a permanent crown is cemented).

• **Deductible** means the amount you pay toward **covered services** before we begin paying benefits. **Deductibles** must be met each **policy year**. **Deductibles** may vary by type of benefits; or, by type of provider (participating vs. non-participating). They are specific dollar amounts for each **subscriber** and/or **dependent** per **policy year** or per lifetime as specified.

• **Dentally Necessary (Dental Necessity)** means that the dental services provided are appropriate, in terms of type, amount, frequency, level, setting, and duration to the **member's** diagnosis or condition. All **covered services** must be **dentally necessary** and appropriate to qualify for payment. **We** will make a determination whether a service is **dentally necessary** based on this “**dental necessity**” standard using criteria which is set forth in the utilization review plan and guidelines (“review guidelines”) that we file with the Rhode Island Office of the Health Insurance Commissioner. These guidelines are based on generally accepted dental or scientific evidence and are consistent with generally accepted practice parameters. If a service is denied based on **dental necessity**, we will send **you** and your **dentist** a written notice explaining the reason(s) for the denial. The notice will refer to a guideline; protocol; or, criteria we used to make the denial. Refer to the **Claims Procedures** section of this **Certificate** for details on how to get more information regarding the review decision and procedures for filing an appeal. A copy of our review guidelines is available on our website at: www.deltadentalri.com.

• **Dentist** means any person licensed as a Doctor of Dental Medicine (DMD) or Doctor of Dental Surgery (DDS) practicing within the authority of his or her license. The term **dentist** includes an oral surgeon.

• **Dependent** typically means **your spouse** and your unmarried dependent children up to a certain age. A **spouse** includes a party to a same sex marriage; civil union; or, similar union entered into under applicable state laws. Refer to your **Benefits Summary** for dependent children age limits. **Your plan sponsor determines dependent eligibility terms.** If you have family coverage, your newborn infant and a newborn infant of a dependent child are eligible for coverage from birth. Adopted children are covered from the date of placement in the home. Foster children are covered from the date of the filing of the petition to adopt. Stepchildren and children under your own or your spouse’s legal guardianship who permanently live in your household and are chiefly dependent on you for support, are also
considered dependent children. Married children are not considered dependents, regardless of their age.

- **Effective Date** means the date as shown in our records on which your coverage begins.

- **Emergency Service** means a service given to treat a person with a serious medical or health problem. That person needs to be seen by a provider right away to prevent permanent damage or death. A medical problem includes physical, mental, and dental conditions. (Emergency service is limited to services which are palliative and/or temporary and does not include services such as permanent fillings, crowns or root canals.)

- **Endodontics** means a specialty of dentistry that deals with treatment of diseases of the dental pulp (nerves, blood vessels and other tissues within the tooth). A root canal is an example of endodontic treatment.

- **Hygienist** means any person licensed as a dental hygienist practicing within the authority of his or her license.

- **Lifetime Maximum** means the most we will pay for covered services during a subscriber's or dependent's lifetime. This usually applies only to orthodontic services and implants if covered by your plan.

- **Local Delta Dental Plan** means the Delta Dental Plan that contracts with the participating dentist in a particular state. There are Delta Dental Plans covering all 50 states.

- **Member** means a Subscriber or Dependent.

- **Non-participating Dentist** means a dentist who does not have a contract with Delta Dental

- **Orthodontics** means a specialty of dentistry concerned with prevention and correction of abnormalities in tooth position and their relationship to the jaw (straightening of teeth).

- **Participating Dentist** means a dentist who has a contract with the local Delta Dental Plan to provide covered services to subscribers and dependents. A participating dentist may belong to the PPO network, the Premier network, or both.

- **Pedodontics** means a specialty of dentistry concerned with the treatment of children.

- **Periodontics** means a specialty of dentistry concerned with diseases of the gums and other supportive structures of the teeth.

- **Plan** means the terms, conditions and benefits described in this Certificate and the Benefits Summary.

- **Plan Sponsor** means your employer or other organization / association that is sponsoring the Plan. In the case of a group subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended, the Plan Sponsor is the individual or entity designated under that Act.
• *Policy Year* means the continuous 12 month period under which coverage is offered by your plan sponsor. *Your policy year* is either the calendar year or the timeframe beginning with your group’s coverage start date and ending 12 months later.

• *Prosthodontics* means a specialty of dentistry concerned with the replacement of missing teeth by bridges and dentures.

• *Spouse* means your legal spouse. A *spouse* includes a party to a same sex marriage; civil union; or, similar union entered into under applicable state laws.

• *Subscriber* means someone who has applied for coverage and been approved by us; and, is eligible to get benefits under this Certificate. In the case of a subscriber who is less than 18 years of age, the parent or legal guardian must contract on behalf of the dependent child for the benefits described in this Certificate. The parent or legal guardian must assure the dependent child’s compliance with any and all terms and conditions outlined in the policy.

• *Waiting Period* is the amount of time you must wait from your effective date before a service is covered. If your plan has a waiting period, it will be shown in the Benefits Summary that goes with this Certificate.

• *We, Our, Us and Delta Dental* means Delta Dental of Rhode Island located at 10 Charles Street, Providence, RI 02904-2208.

• *You and yours* means the Subscriber.

### When You Join the Plan

#### Who Can Join

You and/or your eligible dependents can join the Plan if your Plan Sponsor agrees and complies with our underwriting guidelines. *Your plan sponsor determines eligibility requirements for dependents.* A parent or legal guardian must contract on behalf of a child who is less than 18 years old. The parent or legal guardian is liable for the child’s compliance with any and all policy terms and conditions.

The Plan does not limit coverage based on genetic information. We will not: (i) adjust premiums based on genetic information; (ii) request / require genetic testing; or, (iii) collect genetic information from an individual before, or in connection with, enrollment in a plan; or, at any time for underwriting purposes.

Your eligible dependents typically are:

• *Your legal spouse.* A *spouse* includes a party to a same sex marriage; civil union; or, similar union entered into under applicable state laws. If you divorce, your ex-spouse will remain eligible for continued coverage under
the policy without additional premium until either spouse remarries. This is true unless the divorce or separation judgment states otherwise. If you remarry, the ex-spouse may, if the divorce judgment allows, stay covered as a member at additional premium.

- **Your unmarried dependent children** up to a certain age. Refer to your Benefits Summary for age limits.

- **Your unmarried children who have reached the dependent age limit up to a higher student age limit**, if a student at an accredited secondary school or college and primarily dependent on you for support.

  **NOTE:** Your plan sponsor must agree to purchase coverage for students. If applicable, the student age limit will be listed in your Benefits Summary. Your plan sponsor determines student eligibility terms.

- **Your unmarried children who have reached the dependent age limit; and, who are mentally or physically disabled and cannot earn a living.** You must submit proof of your child’s disability within 30 days of the child reaching the dependent age limit. The proof must be satisfactory to us. You must continue to provide proof of the disability upon request.

**How You Join**

You enroll by completing, signing and returning to us or your plan sponsor an applicable form. Forms are available from us or your plan sponsor, or you may be able to enroll online. If your family status changes and you need to add or remove dependents from your plan, contact us or your plan sponsor. We can only accept membership changes from a subscriber or your plan sponsor.

**When Coverage Begins**

Coverage generally starts the first of the month after we accept your completed and signed enrollment form and payment arrangements.

Your plan sponsor can tell you if there is a waiting period before you can join the Plan.

You must wait until your plan sponsor’s next open enrollment period, if you or your dependent(s) do not enroll when first eligible. You may also enroll when there is a qualifying event. We establish what a qualifying event is. Examples include loss of other coverage, marriage, or death.

If you marry, you may enroll your spouse within 60 days of marriage. You must wait until your plan sponsor’s next open enrollment period if your spouse does not enroll when first eligible. Your spouse may also enroll when there is a qualifying event.
If you have family coverage, your newborn infant and the newborn infant of a dependent child are covered from birth. Adopted children are covered from the date of home placement. Foster children are covered from the date of the petition to adopt filing. Stepchildren and children are considered dependent children if they: are under your own or your spouse’s legal custody; permanently live in your household; and, chiefly depend on you for support. We do not consider married children dependents, regardless of their age.

Coverage generally begins on the first of the month after we accept your enrollment form. If you don’t enroll within 60 days, you must wait until the next open enrollment period to enroll dependents. Dependents may enroll when there is a qualifying event.

Please tell us and your plan sponsor of any changes in your or your dependent’s status. This includes marriage; births; reaching the dependent or student (if applicable) age limits; or, changes in your address. This will help us keep our records up to date.

The Cost of Your Coverage
You and/or your plan sponsor pay the cost of coverage for you and your eligible dependents. The cost of coverage is based on the arrangement agreed to by your plan sponsor. This arrangement must comply with our underwriting guidelines.

When Coverage Ends
Your plan sponsor or we may cancel your group’s coverage under the terms of our contract with your group. If the group’s coverage is cancelled, your coverage will also end on the same date. If your coverage ends, we will give you 30 days prior notice; and, include the reason for terminating your coverage.

In addition, we may cancel your coverage for the following reasons. Coverage generally ends on the last day of the month:

- You are no longer eligible for coverage.
- You or your plan sponsor cancel coverage by completing the applicable form.
- You make any fraudulent claim(s) or misrepresentation to us or to any dentist. Examples include loaning your ID card to someone else; or giving incorrect or incomplete information which led us to believe you were eligible for this coverage when in fact you were not. In such a case, cancellation will be as of your effective date. We will refund the premium charge we received. We will subtract from the refund any payments made for claims under this Certificate. If we have paid more for claims under this
Certificate than was paid to us in premium charges, we have the right to collect the excess from you.

- The premium charge is not paid within 30 days after it is due. Your plan sponsor is allowed a grace period of thirty-one (31) days for the payment of any premium due except the first. The plan sponsor will owe us the premium for the period between the due date and the cancellation date. In the case of a cancellation of your group's contract based on nonpayment of premiums, we will tell you in writing. We will honor any claims for covered services rendered before the written notification date.

However, except for non-payment of premiums, we will not contest the validity of this Certificate after it has been in force for 2 years based on representations made to us before it was in force; or, unless the representation is in writing signed by you; and, we provide a copy of the statement to you.

When Your Dependent’s Coverage Ends
Your dependent’s coverage typically ends:

- When you are divorced from your spouse*, your former dependent spouse will be, unless a court says otherwise, considered your dependent until the earliest of:
  a. the date you remarry, unless a court says you must continue to provide coverage. In that case, your ex-spouse can continue to be covered as a member of the group at an additional premium or
  b. the date your former dependent spouse remarries; or
  c. the date when he/she is no longer eligible for continued coverage as specified by a court; or
  d. the date when you or your spouse cancels coverage; or
  e. the date when your plan would have otherwise ended; or
  f. the date when appropriate premium payments are not made.

* A spouse includes a party to a same sex marriage; civil union; or, similar union entered into under applicable state laws.

- At the end of the month in which an eligible dependent child marries; or

- When a dependent child reaches the dependent age limit as set forth in your plan’s Benefits Summary.

NOTE: If your unmarried dependent child is mentally or physically disabled and has reached the dependent age limit; and, he/she cannot earn a living, you may apply for continued coverage through your plan sponsor. You have 30 days from the date your child reaches the dependent age limit to apply.
You must include the medical reason for your request. We will review your application to decide if it meets our criteria.

NOTE: If your plan sponsor purchased student coverage, your dependent child may be able to continue coverage past the dependent age. The child must be enrolled as a student. If you have such coverage, the option will be listed in your Benefits Summary with a student age limit. Your plan sponsor determines student eligibility terms.

Benefits After Cancellation
All services must be complete to qualify for benefits. For example, permanent crowns must be cemented; bridges or dentures must be inserted. Once your coverage is cancelled, you won’t have benefits for services finished after your cancellation date. Your covered family members won’t have benefits either.

When You May Rejoin the Plan
You may rejoin the same group plan after you cancel, during your group’s next open enrollment period; or, another timeframe specified by your plan sponsor. If your Plan has a waiting period, this waiting period starts again, with the new effective date. We do not reinstate coverage back to the original effective date.

You may join again through a different group plan. You can do this anytime you become eligible for that plan. Lifetime and annual maximums; and, claim history that accumulated while you were covered under a previous plan, or any other plan, may be carried forward to your new plan.

Features of the Plan
Your plan helps you maintain good dental health through regular dental care. It will help you pay for dental expenses. We describe your exact coverage in the Benefits Summary.

Utilization Review Guidelines
Our Dental Case Management area reviews claims. These reviews help us decide if services meet our review guidelines. Claims reviewers are registered dental hygienists; or, dental assistants with clinical experience. They review claims and can approve services. Only a dental consultant, who is a licensed dentist, can deny a claim.

We review claims using written review guidelines. We base these on accepted standards of care in the dental profession. They are backed by statistical studies of practice patterns. They also comply with guidelines approved by
the Delta Dental Plans Association. These guidelines, as well as contract limits, help us make decisions. We create clinical guidelines and utilization review standards with guidance from the Dental Director; in-house dental consultants; and, a dental advisory committee. The committee is made up of participating dentists. Our dental consultants and dental advisory committee study trends in dentistry; the proven value of new materials and procedures; treatment longevity; and, local and national practice patterns.

Quality Management Programs
We strive to provide high quality products and services. We do this by monitoring; identifying; and, tracking key issues over time. We deal with these issues as part of our review of our Quality Program.

Assessment of New Dental Materials and Treatments
We study new dental materials and treatments. We also study how effective they are and the cost. Then, we decide if we will cover the material or treatment.

Continuity of Care
If your dentist moves or decides not to participate, you can choose a new dentist from the network. There will not be a change your coverage or benefits. If you change from a participating dentist to a non-participating dentist, the treatment would still be covered. This is true as long as it is a covered benefit; but, you must pay any difference between our payment and the dentist’s charge.

Pre-treatment Estimate
When treatment is likely to cost more than $300, you and your dentist should get an estimate before you get treatment. This includes treatment such as crowns; periodontic; prosthodontic; and orthodontic services.

After your dentist sends a request, we will review the treatment plan. Then, we will tell you and your dentist what the estimated payment will be for those services.

NOTE: Estimates are based on available benefits. The patient must be a Delta Dental member at the time the service is done. The estimate shows what money is available at the time the estimate is done. This can change because services may no longer be available on the date the service is done. For example, if you had other services paid for after the estimate, and you reach your annual maximum, there will be no money left to pay for the new service. Another example is if you lose coverage before the new service is done.
How to Use Delta Dental
Maximize Your Coverage with Participating Dentists
You have access to the nation’s largest network of dentists. The network includes general dentists and specialists. Members do not need approval from us or their general dentist to see a specialist. This includes dentists that see only children.

By choosing a dentist from the network, you get the best value from your dental plan. That’s because participating dentists agree to accept the allowance as full payment for covered services. That means that they will not bill you for any difference between the amount we allow and their actual charge.

Under your Delta Dental PPO Plus Premier plan, you can choose a participating dentist from either the PPO or Premier networks. That’s because a participating dentist may belong to the PPO network; the Premier network; or to both. Ask your dentist which network(s) he or she belongs to before receiving services. For services that require a coinsurance, you will have lower out-of-pocket costs with a PPO participating dentist. That’s because the PPO allowance is typically less than the Premier allowance.

You also can see a dentist that is not in our network. However, when you go to a non-participating dentist, it will usually cost you more money. That’s because:

1.) You may have to pay a larger percent for services you receive.

2.) You must pay for any difference between the amount we allow and the amount the dentist charges.

3.) The amount we allow may be less than what we allow to a participating dentist.

Finding a Participating Dentist
To find a participating dentist visit our website - www.deltadentalri.com. The network includes general dentists and specialists throughout Rhode Island. In addition, members have access to participating dentists throughout the remaining states through our association with the Delta Dental Plans Association. Follow the directions on our website to find a participating dentist in Rhode Island or in another state. When searching for a dentist outside of Rhode Island, make sure to select either the “PPO” or “Premier” dental plan. You’ll get the names and addresses of dentists in your area; plus, maps and driving directions. You can also call Customer Service for help.

Form #RI PPO Plus Premier (18)
We don’t require you or your dentist to get referrals to see a specialist; however, not all services done by a specialist may be covered under your plan. Check your Benefits Summary for a list of covered services. Participating dentists will file claims on your behalf; and, we will pay them directly.

Payments for Services

Participating dentists will accept your co-pay/coinsurance; plus, our payment as payment in full for covered services. We will pay participating dentists directly.

When your participating dentist provides services that are not covered; or, covered services that do not meet dental necessity criteria, as per our review guidelines; you may be liable for the dentist’s charge.

Your participating dentist may charge you more than the allowance when:

- You or your dependents get covered services; and, you have gone over the annual maximum or lifetime maximum amount for specified services.

- You and your dentist decide to use non-covered services such as, treatments or materials that cost more than those normally given by most dentists or, that are being done to improve your appearance. In these cases, we may pay an allowance suitable for a less costly, generally accepted material or service.

Non-participating dentists do not have a contract with Delta Dental. They haven’t agreed to accept your co-pay/coinsurance; plus, our payment as payment in full for covered services. If you go to a non-participating dentist, your cost for services may be much more than the cost for those same services done by a participating dentist. You are also liable for the difference between our payment; and, the non-participating dentist’s charge. You will also be liable for any deductibles; copayments; and, coinsurance amounts. You may have to file your own claims; and, we usually send the benefit payments to you.

NOTE:

- If you see more than one dentist for the same service; or need more than one visit, the total amount of your benefits will not be more than the amount that you would get if only one dentist gave all the treatment. You may be liable for the difference.

- If you or your dependent has coverage for orthodontic treatment, we will make periodic payments for these covered services, spread over the expected course of the treatment. If you or your dependent is already in active treatment when you/he/she becomes eligible for these
services, we will prorate our payments for the remaining treatment. Should coverage cease during active treatment, we will stop making payments as of the date the coverage ended; regardless of whether or not the treatment is complete.

Emergency Services
We cover services that take place in a dental facility by a licensed dentist, as long as they are covered under your plan. We do not cover services received in a hospital; surgi-center; or, urgent care facility.

In the case of a life-threatening emergency, you should go to the nearest hospital. Hospital claims must be sent to your medical insurance plan. If you have an urgent dental condition, you should go to the nearest dentist’s office. You do not need prior approval. We will only pay for covered services. Most dental offices treat existing patients within 24 hours for an urgent appointment. If you need help finding a participating dentist, call us at 800-843-3582. You can also use our online tool at www.deltadentalri.com.

When Your Benefits May Be Continued
Federal Election to Continue Coverage (COBRA)
You and your dependents may have the right under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), to continue coverage through your plan sponsor. You can contact your plan sponsor about this option.

State Election to Continue Coverage
You and your dependents may have the right to continue coverage for limited periods under different state laws. Under RI COBRA rules, coverage is available in Rhode Island whenever the employment of an insured member of a group health plan (including dental) ends because of involuntary layoff or death; or, because of the workplace ceasing to exist; or, because of the permanent reduction in size of the workforce. Coverage is available to the member whose employment ended; his or her surviving spouse; and any other dependent(s) who were covered under the plan. You will be charged the same monthly premium rate charged to the group.

Eligible persons may elect continuation coverage under the Plan for up to eighteen (18) months from the termination date of the insured member. Contact your plan sponsor for information about these options.
When There is Other Coverage
Right to Receive and Release Needed Information
We have the right to information related to claims filed under the plan. We can get this information from, or give it to, any organization or person with a legitimate interest. When you file a claim, you must give us any information needed to process the claim. You must give us information regarding other insurance coverage when you first enroll. You must also let your dentist know about other coverage when you get care. We will ask you for updated information from time to time.

Coordination of Benefits
Your plan is designed to prevent overpayment of benefits when more than one Plan may cover the service. The other Plan may be a dental Plan or a medical plan that covers certain services also covered under this plan.

When you are covered by more than one Plan, one Plan is the "primary" Plan and the others are "secondary" Plans. When you file a claim, the primary Plan pays benefits first, up to the limits of the Plan. The secondary Plans adjust their benefits so that the total amount paid is not more than the cost of covered services. This process is called "Coordination of Benefits" (COB). If you, or a family member, are also covered by other medical or dental plans, we will coordinate payment with them. We use standard insurance industry guidelines in most cases. The standard guidelines that govern this process are shown below. If other guidelines apply to your plan, they will be in your Benefits Summary.

As used in these rules, the terms "Plan" and "Allowable Expenses" mean:

- "Plan" means any plan providing dental benefits or services, including government and insured or self-insured group or group-type coverages through an HMO or other prepayment, group practice or individual practice plan.

- "Allowable Expenses" means a necessary, reasonable and customary item of expense for dental care, all or part of which is covered by at least one Plan covering the person for whom the claim is made. Where a Plan provides dental benefits in the form of services rather than cash payments, the reasonable cash value of each service received will be considered both an Allowable Expense and a benefit paid.

If you are covered under more than one Plan, the total payment you get will never be more than your Allowable Expenses.
The National Association of Insurance Commissioners makes the rules about which Plan is primary; including:

- The Plan without a coordination of benefits provision is primary.
- When another Plan’s rules and this plan’s rules require this plan to pay its benefits first, this plan is primary.
- The Plan covering the patient directly rather than as an employee’s dependent is primary.
- If a child is covered under both parents’ Plans, the Plan of the parent whose birthday falls earlier in the calendar year is primary (the "birthday" rule) unless the other Plan has a "gender" rule.
- If a child is covered under both parents’ Plans and the other Plan has a "gender" rule, the rule in the other Plan determines benefits. (The "gender" rule says that if a child is covered under both parents’ Plans, the Plan of the male parent is primary).
- If the "birthday" rule applies, and both parents have the same birthday, the Plan covering a parent longest is primary.
- If the parents are separated or divorced, benefits for the child are decided in this order:
  - The Plan of the parent with custody.
  - The Plan of the spouse of the parent with custody.
  - The Plan of the parent not having custody, unless one of the parents is made responsible for the child’s health expenses by a court decree.
- If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined above.
- If a full-time student is eligible for coverage as a dependent under this Certificate, the benefits of any other coverage available because of student enrollment (except accident-only type coverage) will be determined before the benefits under this plan.
- The benefits of a Plan that covered a person as an employee who is neither laid off nor retired are determined before those of a Plan that covers that person as a laid off or retired employee. The same is true if a person is a dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
• If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the benefits are determined in the following order:
  ◦ First, the benefits of a Plan covering the person as an employee, member or subscriber (or as that person’s dependent);
  ◦ Second, the benefits under the continuation coverage.
  ◦ If the other plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
  ◦ If payment responsibility is still unresolved, the Plan covering the patient longest is primary.

In general, if you exceed your benefits for a calendar year, the primary insurer will cover you up to its allowance. The secondary insurer will cover any allowable benefit you use over that amount. The insurers will never pay more than the total amount of coverage that would have been given if benefits were not coordinated.

Subrogation
If someone caused your illness or injury, you may have the legal right to get back some of your dental care costs. When you have this right, you must let us use it if we decide to get back any payments we made for services related to the illness or injury. If you use this right to get money back from someone else, you must repay us for the payments we made. Our right to repayment comes first. It can be reduced only by our share of your reasonable cost of collecting your claim against the other person; or, if the payment received is for “other than dental expenses.” You must give us information and assistance and sign documents needed to help us get our payment back. You must not do anything that might limit our repayment.

Facility of Payment
If another Plan pays a benefit that should have been paid under this plan, we may reimburse the other Plan for that amount. It will be considered a benefit paid by this plan.

Right of Recovery
If we pay more than we should have paid under the COB provision, we have the right to get back the excess amount we paid. We can recoup from other insurance companies and organizations. We can get back the reasonable cash value of any benefits provided in the form of services.
When You Have a Claim  
When to File a Claim  

*You* should send *us* completed claim forms for services covered under this *Certificate*. *You* have 12 months from the date *you* get services. All services must be complete to qualify for benefits; e.g., permanent crowns cemented; bridge or denture inserted. *Participating dentists* will submit claim forms on *your* behalf. *You* will not be responsible for payment on covered services when a *participating dentist* submits claims more than 12 months after the date *you* get the service; except, for any *deductibles; copayments; coinsurance*; or, amounts more than the *annual or lifetime dollar maximums*. *We* will deny claims that a *non-participating dentist* sends to *us* more than 12 months after *you* get the services. *You* must pay such claims, unless the failure to submit a claim within 12 months was because of a legal incapacity.

How to File a Claim  

**Participating Dentist**

When *you* go to a *dentist* who has agreed to participate, *your* claim will be filed for *you*. It will include all necessary supporting information, such as x-rays. *We* accept claims from *dentists* on paper and in an electronic, HIPAA compliant format.

**Non-participating Dentist**

When *you* go to a *dentist* who is not participating, *you* must mail the claim to the following address. *You* don’t have to do this if the *dentist* agrees to file it for *you*. Dental claim forms are available on *our* website at [www.deltadentalri.com](http://www.deltadentalri.com); or, from *your* dentist.

MAIL CLAIMS TO:  
Delta Dental of Rhode Island  
P.O. Box 1517  
Providence, RI 02901-1517

**Claims Procedures**

Call Customer Service if *you* have a question about how a claim was paid, or why we denied it. The number is 401-752-6100 or 800-843-3582. Customer Service representatives are available Monday – Thursday from 8 a.m. to 7 p.m. ET, and Friday from 8 a.m. to 5 p.m. ET. *You* have a right to request a full and fair review of *your* claim. **To consider a claim for payment, we must get it within 12 months of the date you get the service.**

**Pre-treatment Estimates**

A pre-treatment estimate is a claim that is filed before *you* have a dental service. When treatment is likely to cost more than $300, *you* and *your* *dentist* should get an estimate before *you* get treatment. This includes
treatment such as crowns; periodontic; prosthodontic; and orthodontic services.

After your dentist sends a request, we will review the treatment plan. After this review, we will tell you and your dentist what the estimated payment will be for those services.

NOTE: Estimates are based on available benefits. The patient must be a Delta Dental member at the time the service is done. The estimate shows what money is available at the time the estimate is done. This can change because benefits may no longer be available on the date the service is done. For example, if you had other services paid for after the estimate, and you reach your annual maximum, there will be no money left to pay for the new service. Another example is if you lose coverage before the new service is done.

We must have all of the information we need to review the plan; and, to make a benefit decision. We will send you written notice of our initial decision. We will send this notice within 15 calendar days. For urgent or emergency cases, we will give you our decision within 72 hours.

If the service is denied, the notice will explain the reason(s) for the denial. The notice will include the process for filing an appeal. Once a denial is made, you have 180 days from the day you get our notice to file an appeal.

Post-service Claims
A post-service claim is a claim that is filed after dental care is done. All services must be complete to qualify for benefits; e.g., permanent crowns must be cemented; bridges or dentures must be inserted. We will send you written notice of an adverse benefit decision. You will get this notice within 30 calendar days of the day we get the claim. We will send you a notice if we can’t process a post service claim because information is missing. The notice will be sent to you within 30 days. It will tell you what additional information we need to process the claim. A participating dentist must give us the information we need to process a claim. If not, the dentist may not charge the patient for any un-paid amount. Refer to the Expedited Reviews section for claims involving urgent or emergency services.

We will pay your claim within 40 days after we get of a complete paper claim; and, within 30 days after we get a complete electronic claim. A complete claim has all the supporting documents we need to make a claim decision. If we do not pay within this time, we will pay interest on the amount not paid. Interest will be paid at a rate of 12 percent per year in accordance with applicable law.
If the service is denied, the notice will explain the reason(s) why. It will include the process for filing an appeal. Once a denial is made, you have 180 days from the day you get our notice to file an appeal.

**To Appeal an Adverse Benefit Decision**

If you get an adverse benefit decision, you have the right to have it reviewed. An adverse decision means a decision not to approve a service, in whole or in part. Adverse benefit decisions include:

- **Administrative adverse benefit decisions.** These do not require us to use dental judgment; or, clinical criteria. Examples include decisions not to approve because a member is not eligible for coverage; or, a decision that a benefit is not a covered benefit under the Plan; or, that the waiting period has not been met; or, that the frequency on a service has gone above the limit.

- **Non-administrative adverse benefit decisions.** These require us to use dental judgment; or, clinical criteria to determine if the service is dentally necessary. These decisions are made by dentists using our review guidelines. Our guidelines detail the clinical criteria that must be met for a service to be covered. These guidelines are found at deltadentalri.com.

Follow the process below to file an appeal. If you feel that we did not follow the appeals process as described here, you may contact the Rhode Island Resource, Education and Assistance Consumer Helpline (RIREACH). They are found at 1210 Pontiac Ave., Cranston, RI 02920, 1-855-747-3224, www.rireach.org. This is Rhode Island’s Health Insurance Consumer Assistance Program.

**When to File an Appeal:** You must file your appeal within 180 days of the date you get the original coverage denial.

**How and Where You Can File an Appeal:** You must file an appeal in writing. For urgent or emergency services*, you may call Customer Service to start an appeal. Send your appeal to: Delta Dental of Rhode Island, Attn: Appeals, P.O. Box 1517, Providence, RI, 02901-1517. Your appeal should ask us to reconsider. Tell us why you believe the service was wrongly denied. Include a copy of the Explanation of Benefits or Pre-treatment Estimate notice. Include the patient’s name; the subscriber identification number; and, a detailed description of your concern. Appeals of decisions based on dental necessity should also include clinical treatment notes; narratives; photos; x-rays; charting; and, any other necessary clinical documents that support your claim. To be covered, services must meet the criteria in our review guidelines. These are found at deltadentalri.com. Your appeal will be reviewed based on the material you send us. If the file is incomplete, we might not have all the information we need to make an appropriate decision. You should add any information that is relevant to reviewing the appeal.
The Explanation of Benefits or Pre-treatment Estimate notice has numbered messages. These messages explain the reason(s) for our denial. They also refer to any plan terms the decision was based on; and may refer to any guideline; protocol; or, criteria we used to make the denial. You have the right to see copies of all documents related to the claim. We will also give you a copy of any internal rule; guideline; or, protocol we used. We will also explain the scientific or clinical judgment we used to decide the claim. We will give you this information, if you ask for it, at no charge.

**Who Will Review Your Appeal:** Appeals will be researched by an Appeals Coordinator. He or she will talk with appropriate departments. Decisions will be made by those who know about the issues involved in your appeal. Appeals of non-administrative adverse benefit decisions will be reviewed by a licensed dentist. He or she will not have been involved in any prior reviews. The reviewer will not have been involved in the direct care of the patient.

**Response to Your Appeal:** We will reconsider our decision; and, send you a written response within 15 calendar days of receiving your appeal (72 hours for urgent or emergency services). If we do not change our decision, you have 180 days from the date you get our notice to continue the appeal process. Send us a written request for an appeal. We will send you a written response within 15 calendar days of receiving your request (72 hours for urgent or emergency services). Before we make a final internal appeal decision, you have the right to inspect the entire appeal file. You may add information. Additional information must be sent in writing. We will keep it confidential according to applicable state and federal laws.

**External Review Option:** If your final internal appeal to reverse a non-administrative adverse benefit decision is denied, you may request an external appeal. External appeals are sent to an independent review agency. You have 125 calendar days from the date you get our final internal appeal decision to send your request to us in writing. You can add information to the file for review. Send it to us in writing within 5 business days after starting the appeal. We will send all documents we reviewed to the review agency.

**Cost for External Review:** You must pay $50 (up to a maximum of $150 per policy year per member). Include a check made payable to Delta Dental of Rhode Island with your request.

**Response to Your External Appeal:** The review agency will notify you about the outcome of your appeal. They will do so within 10 calendar days of receiving all information needed to complete the review. If the external review agency overturns our decision, we will reimburse you for your share of the fee. We will do this within 60 days of the notice of overturn.

Form #RI PPO Plus Premier (18)
**Additional Information:** Under certain conditions, once the internal appeals process is done, the *member* may also have the right to bring a civil action. This right is given under Section 502(a) of the ERISA Act. The *member* does not have this right if he/she is a member of a governmental plan; church plan; or, a plan not established or maintained by an employer.

**Expedited Reviews**

If *your* claim involves urgent or emergency services as defined below, *you* have the right to a speedy review. *We* will complete *our* review and make a decision within 72 hours. *We* must have all the information *we* need to review the claim. Call Customer Service to obtain a speedy review.

**“Urgent services” includes those resources necessary to treat a symptomatic health care condition that a prudent layperson, acting reasonably would believe necessitates treatment within a 24 hour period of the onset of such a condition in order that the patient’s health status not decline as a consequence. This does not include “emergency services” as defined below.**

**“Emergency services” means those resources provided in the event of the sudden onset of a health condition that the absence of immediate medical attention could reasonably be expected, by a prudent layperson, to result in placing the patient’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.**

**Resolution of Inquiries and Complaints**

**Inquiries**

If *you* have questions or concerns, send an email to customerservice@deltadentalri.com. *We* will try to resolve it as soon as *we* can. *Our* appeals process tells *you* how to appeal a claim decision.

**Complaints**

If *you* have a complaint, send an email to customerservice@deltadentalri.com or, call us at 401-752-6100 or 800-843-3582. *We* settle most complaints on first contact. However, if *your* complaint needs more research (e.g., it involves quality of care; fraud; or, abuse, etc.), *we* will settle it as soon as *we* can. If *you* are not satisfied, *you* may call the Rhode Island Office of the Health Insurance Commissioner.

**Consumer Assistance Resource**

If you need help with an appeal or complaint, you may contact the Rhode Island Resource, Education and Assistance Consumer Helpline (RIREACH) at 1210 Pontiac Ave., Cranston, RI 02920, 1-855-747-3224, www.rireach.org. This is Rhode Island’s Health Insurance Consumer Assistance Program.
Other Provisions

Claims Review
This Certificate provides coverage only for dentally necessary and appropriate care. The decision whether a service is dentally necessary is solely for the purpose of claims payment. It is not a professional dental judgment. You have the right to appeal our decision. Refer to the Claims Procedures section, and the definition of “dentally necessary” in the Definitions section.

Although we may conduct review, we do not act as a dentist. We do not provide dental care. We do not make dental judgments. Nothing here changes or affects your relationship with your dentist.

Access to Records
When you file a claim, you agree to give us the right to get, from any source, all dental records and/or related information that we need. We will keep your information confidential. We can also have a licensed dentist examine, at our expense, any person making a claim. You agree that dentists may give us individually identifiable health information. You also agree that we may use and disclose such information as described in our Notice of Privacy Practices. You can find this Notice on our website. You can also call Customer Service for a copy.

Participating dentists must give us all of the information we need to process your claim. They will not charge for this service. Non-participating dentists in Rhode Island must do this too.

If you get services outside Rhode Island from a non-participating dentist, you must help us get all of the records we need. We will not pay the dentist for giving us this information. If the non-participating dentist does not give us this information, we may not provide benefit payments to you.

Document Changes
We or your plan sponsor may change your Certificate. This is usually done on your group’s anniversary date. Your plan sponsor will notify you. We are not responsible if he or she does not. Your Certificate will be changed whether or not you have been notified by your plan sponsor. There will be an effective date for any change. The change will apply to all benefits for services you get on or after the effective date. No agent or broker has authority to change or waive any of the provisions of this Certificate. No change in the Certificate shall be valid unless approved by an officer of Delta Dental of Rhode Island; and made a written part of this Certificate or the accompanying Benefits Summary.
Notices

To You: When we send a notice, we will send it by first class mail, e-mail or fax. Once we send the notice, we are not responsible for its delivery. It will be your plan sponsor’s responsibility to notify you if the notice is sent to your plan sponsor. This applies to any bills for premium charges and, to a notice of a change in the premium charge or a change in the Certificate. If your name or mailing address changes, tell us and your plan sponsor at once. Be sure to give us and your plan sponsor both your old name and address and your new name and address.

To Us: Email us at customerservice@deltadentalri.com or send mail to:

Delta Dental of Rhode Island
P.O. Box 1517
Providence, RI 02901-1517.

Always include your name; and, your ID number.

Acts of Providers
We will not get involved with the relationship between dentists and patients. We are not responsible if a dentist refuses to treat you. We are not liable for injuries or damages resulting from the acts or omissions of a dentist. We are not responsible if you are dissatisfied with the treatment or services your dentist provides.

Right to Recover Overpayments
If we pay more than we should, we can get payment back from either you; or, the dentist. We can also deduct any payment we have made from any benefits properly paid under this policy if the payment was made:

1. In error; or
2. Due to a misstatement in a proof of loss; or
3. Due to fraud or misrepresentation of a material fact to procure coverage or under the terms of the coverage; or
4. For an ineligible person; or,
5. Due to a claim for which benefits are recoverable under any policy or act of law providing coverage for occupational injury or disease, to the extent that such benefits are recovered.

If we have already made claim payments to a covered person; we can reduce the payment we would make on a future claim to recoup an overpayment.
Legal Actions
You are not allowed to file a lawsuit against us regarding a claim for benefits until at least sixty (60) days after you have submitted the claim. Also, you may not file a lawsuit against us regarding a claim for benefits more than 3 years after you are required to submit the claim.

Conformity with Applicable Laws
We amend any term of this Certificate which conflicts with any relevant law. We do this to conform to the minimum requirements of such law.

This Certificate, and the Benefits Summary, is a description of your benefits; rights; and, obligations under the plan.

Your subscriber ID card identifies you as a person with these benefits. Please show the ID card to your dentist whenever you or your dependents get services.

Preexisting Conditions
There are no preexisting condition limitations in this plan.

Waiting Periods
Some dental plans require you to wait a certain amount of time before they will cover a given procedure. This is called a waiting period. If your plan has a waiting period, it will be noted in the Benefits Summary.

Services Not Covered by the Plan
Unless otherwise stated in the Benefits Summary, the following are not covered:

• Services that are not dentally necessary and appropriate according to our review guidelines. Services subject to these guidelines include, but are not limited to, root canals; crowns and related services; bridges; periodontal services; orthodontics; and, oral surgery. We will make a decision whether a service dentally necessary based on these guidelines. A service may not be covered under these guidelines even if it was recommended by a dentist. Our guidelines can be found on our website at www.deltadentalri.com. You can have your dentist send us a request for a pre-treatment estimate in advance of the service to see if the service meets our guidelines.

• Services greater than the annual maximum.
• Services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustee or similar person or group.
• An illness or injury that we decide is employment-related.
• Services you would not have to pay for if you did not have this Delta Dental coverage.
• Services or supplies that are experimental in terms of generally accepted dental standards.
• Services done by a dentist who is a member of your immediate family.
• An illness, injury or dental condition for which benefits are, or would have been available, through a government program if you did not have this Delta Dental coverage.
• Services done by someone who is not a licensed dentist or a licensed hygienist working as authorized by applicable law.
• Exams by specialists, except for periodic oral exams.
• Consultations.
• Disorders related to the temporomandibular joints (TMJ), including night guards and surgery.
• Services to increase the height of teeth or restore occlusion.
• Restorations needed because you grind your teeth or due to erosion, abrasion, or attrition.
• Services done mainly to change or to improve your appearance.
• Orthodontics.
• Occlusal guards.
• Implants.
• Bone grafts.
• Splinting and other services to stabilize teeth.
• Laboratory or bacteriological tests or reports.
• Temporary, complete dentures or temporary, fixed bridges or crowns.
• Prescription drugs.
• Guided tissue regeneration.
• General anesthesia or intravenous sedation for non-surgical extractions, diagnostic, preventive, or minor restorative services.
• General anesthesia or intravenous sedation given by anyone other than a dentist.
We can adopt; and, apply, policies that we deem reasonable when we approve the eligibility of *subscribers*; and, the appropriateness of treatment plans and related charges.
CHILDRN'S FRIEND AND SERVICE
HEALTH FLEXIBLE SPENDING
ACCOUNT
PLAN DOCUMENT

Effective January 01, 2021
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CHILDREN'S FRIEND AND SERVICE
HEALTH FLEXIBLE SPENDING ACCOUNT

Children's Friend and Service (the “Employer”) hereby sets forth the Children's Friend and Service Health Flexible Spending Account (“Health FSA” or “the Plan”), as in effect January 01, 2021.

ARTICLE I
Purpose

The purpose of this Health FSA is to permit Eligible Employees to elect to make pre-tax contributions to pay for qualified medical expenses incurred by Eligible Employees and their family members. Contributions made under the Plan are not taxable to the employee. The Plan is intended to be a “cafeteria plan” as described in Section 125 of the Internal Revenue Code, as amended, and the regulations thereunder.

ARTICLE II
Definitions

2.1 “Benefits Account” means an account maintained on the books of the Employer for each Participant in accordance with Article IV for the purpose of recording the Participant’s contributions to this Health FSA.

2.2 “Code” means the Internal Revenue Code of 1986, as amended from time to time.

2.3 “Dependent” means an Employee’s Spouse (as defined in Section 2.13) and the Employee’s child(ren) if under age 27 as of the end of the Employee’s taxable year (or such other age as determined by the Plan Administrator and permitted under applicable law).

2.4 “Eligible Employee” means any person as defined in Section 3.1. Non-resident aliens, independent contractors and individuals designated by the Employer as temporary employees shall not be Employees for purposes of this Plan. Leased employees within the meaning of Sections 414(n)(2) and 414(o)(2) of the Code, and employees subject to collective bargaining agreements may be included in the definition of Employee only at the discretion of the Employer.

2.5 “Employer” means Children's Friend and Service, and any entity which succeeds to the business and assumes the obligations of the Employer.

2.6 “Medical Care” means medical care as defined in Code Section 213(d), which includes amounts incurred by the Participant, Spouse or Dependent(s) for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or
function of the body; for transportation primarily for and essential to Medical Care; and for health insurance co-pays and deductibles.

However, Medical Care shall not include health insurance premiums; long-term care services as defined in Code Section 7702B(c); or Medical Care expenses that have already been reimbursed, or are eligible to be reimbursed, by insurance or otherwise, among other exclusions. For expenses incurred prior to Jan. 1, 2020, Medical Care shall not include expenses incurred for any medicine or drug (other than insulin) that is not “prescribed” within the meaning of Code Section 106(f).

2.7 “Participant” means an Eligible Employee who has satisfied the requirements of Article III; and whose participation has not terminated in accordance with Article III, Section 3.5.

2.8 “Participating Employer” means any member of the following group including the Employer, if such member adopts this Health FSA with the Employer’s authorization as provided in Article XII, Section 12.1 and meets the definition of an Employer as described in Section 2.5: (i) a controlled group of corporations, within the meaning of Section 414(b) of the Code; (ii) a group of trades or businesses under common control, within the meaning of Section 414(c) of the Code; (iii) an affiliated service group, within the meaning of Section 414(m) of the Code; or (iv) a trade or business required to be aggregated pursuant to Section 414(o) of the Code. Each Participating Employer is identified in Appendix A. The Employer shall amend Appendix A as needed, to reflect a Participating Employer’s adoption of or withdrawal from this Health FSA, without any need to otherwise amend this Health FSA. Amendment of Appendix A may be made by any authorized officer or representative of the Employer and shall not require approval of the Board of Directors.

2.9 “Period of Coverage” means the Plan Year; provided, however, that with respect to a Participant who commences participation after the beginning of a Plan Year, the initial Period of Coverage shall run from the effective date of the Participant’s participation to the end of that Plan Year, and all subsequent Periods of Coverage shall be on the Plan Year basis.

2.10 “Plan Administrator” means the Employer or such other individual, committee or firm as the Employer shall designate from time to time.

2.11 “Plan” means the Children’s Friend and Service Health Flexible Spending Account Plan as set forth herein and as amended from time to time.

2.12 “Plan Year” means the twelve consecutive month period ending on December 31.

2.13 “Spouse” means an individual who is treated as a spouse under federal tax law.
ARTICLE III

Eligibility and Participation

3.1 Eligibility Requirements. An Employee is generally eligible to participate in the Plan if he or she meets the requirements of Section 2.5 and is also eligible to enroll in the Employer’s group health plan.

3.2 Eligible Classification. An Employee shall not be an Eligible Employee while he or she is a member of a classification of Employees which the Plan Administrator has designated as not currently eligible to participate in the Plan. The Plan Administrator may at any time and from time to time remove any one or more Employees or group(s) or class(es) of Employees from eligibility for participation in this Plan, provided that in no event shall any such removal reduce the amount theretofore credited to the Benefits Account of any Participant.

3.3 Determination of Eligibility by Plan Administrator. The determination of an Employee’s eligibility to become and continue as a Participant in the Plan shall be made by the Plan Administrator from the Employer’s or Participating Employer’s records, and the Plan Administrator’s determination shall be binding and conclusive upon all persons.

3.4 Enrollment. An Eligible Employee must annually complete any Enrollment Form required by the Plan Administrator to enroll in the Health FSA, and to elect the amount of pre-tax contributions for the Period of Coverage. Such Enrollment Form must be completed, executed, and returned to the Plan Administrator by the applicable deadline. Such coverage will be effective as soon as administratively possible after the completed Enrollment Form is received.

3.5 Termination of Participation. A Participant will cease to be a Participant in this FSA upon the earlier of the termination of the FSA or the date on which the Participant ceases to be an Eligible Employee (because of retirement, termination of employment, layoff, reduction in hours, or any other reason), provided that eligibility may continue beyond such date under generally applicable criteria determined in the sole discretion of the Plan Administrator. Reimbursements from the FSA after termination of participation will be made pursuant to Section 6.7 (relating to a run-out period for submitting claims incurred prior to termination).

ARTICLE IV

Accounts and Funding

4.1 Accounts. All amounts credited to a Participant’s Benefits Account shall remain the property of the Employer until paid out pursuant to the Plan. In no event shall any interest or other income be allocated to a Benefits Account. The Plan Administrator will not create a separate fund or otherwise segregate assets for this purpose. The Benefits Account will merely be a recordkeeping account with the purpose of tracking contributions and available reimbursement amounts. In no event shall benefits be provided other than for reimbursement for eligible Medical Care expenses.
4.2 **Funding.** A Participant may elect a specific amount to be contributed via salary reduction, subject to the contribution limits described in Section 4.3, to pay for qualified Medical Care expenses incurred by the Participant and the Participant’s Spouse and Dependents.

The Employer may, at its sole discretion, contribute to a Participant’s Benefits Account, subject to applicable limits prescribed by law. Any Employer contributions shall be calculated for each Plan Year in a uniform and nondiscriminatory way. Any amounts credited by the Employer may vary from year to year. However, the maximum benefit payable to any Participant cannot exceed two times the Participant’s salary reduction election under the Plan for the year (or, if greater, cannot exceed $500 plus the amount of the Participant’s salary reduction election). Unused carryover amounts as described in Section 4.4 are not taken into account for this purpose.

4.3 **Contribution Limits.** The amount of a Participant’s salary reduction contributions for a Plan Year shall not exceed any applicable limits prescribed by law (including the limit in Code Section 125(i), to the extent it is effective for the Plan Year). In addition, the Plan Administrator may impose additional contribution limits beyond those prescribed by law. Unused carryover amounts as described in Section 4.4 are not taken into account for purposes of these limits.

4.4 **Unused Funds Remaining at End of Plan Year.** A Plan Participant may carry over unused Benefits Account funds to the next Plan Year, up to the carry-over limit in effect for the Plan Year. Any funds in excess of the maximum carryover amount will be forfeited in accordance with the requirements of the Code.

**ARTICLE V**

**Claims Procedure**

5.1 **Expense Reimbursement Procedure.** Reimbursement of Medical Care expenses shall be made in accordance with the following rules:

(a) To receive reimbursement for Medical Care expenses from his or her account, a Participant must submit a written application not later than 30 days following the end of the Plan Year in which such Medical Care expenses were incurred or billed to the Participant, in accordance with such rules, practices and procedures as the Plan Administrator may specify, in its discretion, for the reimbursement of Medical Care expenses from the Participant’s account, including rules that do not invalidate an application that is submitted later than 30 days following the end of the Plan Year provided the application is filed as soon as reasonably possible.

(b) The Plan Administrator reserves the right to verify to its satisfaction all claimed Medical Care expenses prior to reimbursement. Each request for reimbursement shall include such substantiation as required by the Plan Administrator, which may include the following information:
(i) the name, Social Security number, and address of the employee;

(ii) the name and date of birth of the person for whom the Medical Care expense was incurred and, if such person is not the Participant requesting reimbursement, the relationship of the person to such Participant and a statement that such person is a Dependent of such Participant;

(iii) the name and address of the person, organization or other provider to whom the Medical Care expense was or is to be paid;

(iv) a written statement from an independent third party setting forth the type, purpose, date and amount of the Medical Care expense for which reimbursement is requested; and

(v) a statement that the Participant has not been reimbursed and that the Medical Care expense is not reimbursable by insurance or otherwise.

(c) The Plan Administrator may require the Participant to furnish a bill, receipt, canceled check, or other written evidence of obligation to pay Medical Care expenses. The Plan Administrator reserves the right to require the Participant to provide, to the Plan Administrator’s satisfaction, further proof of any of the above-described information and other information reasonably necessary to determine the eligibility for and amount of any reimbursement from the Participant’s account. The Plan Administrator may require the Participant to provide written authorization to obtain information from any group medical, HMO, dental, vision care, prescription drug, or other health benefit plans in which Participant or his or her Dependents are enrolled.

(d) Expenses eligible for coverage under any group medical, HMO, dental, vision care, prescription drug, or other health plans or insurance coverage in which the Participant or his or her Dependents are enrolled must be submitted first to all such plans or insurers in accordance with the rules of those plans or insurers, and be finally adjudicated under those plans or insurers, before submitting the expenses to the Employer for reimbursement under the Plan.

(e) Subject to applicable law, the Plan Administrator may establish such rules as it deems desirable regarding the frequency of reimbursement of Medical Care expenses and the minimum dollar amount that may be requested for reimbursement.

5.2 Claims for Reimbursement.

(a) In General. This Section is intended to comply with Department of Labor Regulations 2560.503-1 and 2590.715-2719, and shall apply specifically to claims under a group health plan as defined in Department of Labor Regulation 2560.503-1.
(b) Written Claim for Benefits. If a claimant asserts a right to any benefit under the Plan, the claimant must file a written claim for such benefit with the Plan Administrator (as defined in Section 2.10 of this plan document). For purposes of this Section, claimant shall mean any Participant, Spouse, Dependent, or Beneficiary or authorized representative who files a claim for benefits.

(c) Upon the denial of a claim, the Plan Administrator shall notify the claimant in writing of such denial within 30 days of receipt of the claim. The Plan Administrator shall be permitted one 15-day extension to the 30-day claim determination period, provided that the Plan Administrator determines that such extension is necessary due to matters beyond the Plan’s control and notifies the claimant before the end of the initial 30-day period of the circumstances necessitating the extension of time and the date by which the Plan intends to render a decision. If such extension is required due to the claimant’s failure to submit all information necessary to decide the claim, the extension notification must specifically describe the required information and the claimant shall have 45 days from receipt of the notice to provide the requested information. Failure by the claimant to provide requested information shall result in the denial of the claim. A denial notice shall explain the reason(s) for denial, refer to the Section(s) of the Plan on which the denial is based, and provide the claim appeal procedures. The denial notice must also comply with any additional requirements described in Department of Labor Regulation 2590.715-2719.

(d) Appeal of Claim Denial.

(i) Any claimant shall have the right to appeal an “adverse benefit determination” as defined in Department of Labor Regulation 2590.715-2719 within 180 days of receipt of such adverse benefit determination. Any appeal shall be submitted to the Plan Administrator in writing. If the appeal relates to a claim for payment, the claimant’s request should include: the patient’s name and plan identification number; the date(s) of health care service(s); the provider’s name; the reason(s) the claimant believes the claim should be paid; and any documentation or other written information to support the claimant’s request for claim payment.

(ii) An appeal shall be determined by an individual who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor a subordinate of that individual. If the appeal is related to medical matters, the appeal shall be reviewed in consultation with an independent and impartial health care professional who has appropriate training and experience in the particular field of medicine in order to make the health care judgment and who was not involved in the prior determination. The Plan Administrator may consult with, or seek the participation of, independent and impartial medical experts as part of the appeal resolution process. The claimant consents to this referral and the sharing of pertinent health claim information. Upon request and free of charge the claimant has the right to reasonable access to and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits.

(iii) Upon being notified of an adverse determination under an appeal, the claimant shall be permitted, within 60 days of receiving notice of such determination, to
submit notice of a “second-level appeal” to the Plan Administrator. A second-level appeal shall be decided in accordance with the rules in paragraph (ii).

(e) **Timeframes for Appeals Determinations.**

The Plan Administrator shall have 30 days, upon receiving notice of appeal (or second-level appeal) of the denial of benefits, to notify the claimant electronically or in writing of the appeal determination.

The Plan Administrator has the exclusive right to interpret and administer the provisions of the Plan and its decisions with respect to claims are conclusive and binding.

(f) **External Appeals.**

If required by applicable law, when a Participant exhausts all internal appeals procedures, the Participant may commence an external review. The external review process will comply with applicable state or federal law and other rules and procedures as prescribed in Department of Labor Regulation 2590.715-2719.

**ARTICLE VI**

**Payment of Benefits**

6.1 **Participant’s Medical Care Reimbursement.** Benefits shall be debited from time to time under this Article VI from a Participant’s Benefits Account to reimburse or pay for qualified Medical Care expenses. For purposes of reimbursement, the Plan Administrator reserves the right to define qualified Medical Care expenses more narrowly, which may be outlined in a separate communication. Each Participant shall be entitled to reimbursement or payment of Medical Care expenses incurred by such Participant, and his or her Spouse and Dependents.

Subject to Sections 4.2 and 4.3, the payment or reimbursement shall, at all times during the Period of Coverage, be any amount up to the Participant’s maximum benefit under this Health FSA for the Plan Year, less the amount of Medical Care expenses previously paid or reimbursed during the Plan Year with respect to the Participant, and his or her Spouse and Dependents. In the event claims for reimbursement or payment exceed the balance in the Participant’s Benefits Account, the Plan shall pay such claims and the account shall be reduced to a negative balance.

6.2 **Assignment of Benefits.** No benefit payable at any time shall be assignable, transferable, or subject to any lien, in whole or in part, either directly or by operation of law, or otherwise, and none of the following shall be liable for, or subject to, any obligation or liability of any Participant (e.g., through garnishment, attachment, pledge or bankruptcy): this Health FSA, the Plan Administrator, or the Employer.
6.3 Payment to Representative. In the event that a guardian, conservator or other legal representative has been duly appointed for a Participant entitled to any payment under this Health FSA, any payment due the Participant may be made to the legal representative making the claim. If a Participant dies while benefits under this Health FSA remain unpaid, the Plan Administrator may make payment to the executors or administrators of the Participant’s estate. Payment in the manner described above shall be in complete discharge of the liabilities of this Health FSA and the obligations of the Plan Administrator and the Employer.

6.4 Responsibility for Payment. It is the Participant’s responsibility, in all cases, to pay for Medical Care expenses. Any benefit payment made directly to a Participant or the Participant’s representative for a Medical Care expense shall completely discharge all liability of this Health FSA, the Plan Administrator, and the Employer with respect to such expense.

6.5 Overpayments. If, for any reason, any benefit is erroneously paid or exceeds the amount payable on account of a Participant’s Medical Care expenses, the Participant shall be responsible for refunding the overpayment to the Health FSA. The refund shall be in the form of a lump-sum payment, a reduction of the amount of future benefits otherwise payable under this Health FSA, or any other method as the Plan Administrator, in its sole discretion, may require.

6.6 Coordination with Other Sources. Reimbursement of Medical Care expenses under this Health FSA shall be permitted only to the extent that such Medical Care expenses have not been previously reimbursed and are not reimbursable from another source. To the extent that a Medical Care expense is reimbursable from another source, the other source shall provide reimbursement prior to any reimbursement from this Health FSA.

6.7 Reimbursements After Termination. Except as provided in Section 13.4, a Participant shall not receive reimbursements or payments for Medical Care expenses incurred after his or her participation terminates. However, such Participant (or the Participant’s estate) may claim reimbursement or payment for any Medical Care expenses incurred during the Period of Coverage prior to termination of participation; provided, however, that the Participant (or the Participant’s estate) files a claim within 90 calendar days from the date he or she ceases to be a Participant under Section 3.5.

6.8 Participant’s Responsibilities. Each Participant shall be responsible for providing the Plan Administrator with his or her current address. Any notices required or permitted to be given to a Participant hereunder shall be deemed given if directed to the address most recently provided by the Participant and mailed by first class United States mail. The Plan Administrator and the Employer shall have no obligation or duty to locate a Participant who does not provide a current address. In the event a Participant becomes entitled to payment under this Health FSA and such payment cannot be made, for any reason, the amount of such payment, if and when made, shall be determined under the provisions of this Health FSA without any consideration to interest payments which may have accrued.

6.9 Missing Person. If, within one year after any amount becomes payable under this Health FSA to a Participant, the Participant has not accepted or been available to receive the reimbursement, the amount shall be forfeited to the Employer and shall cease to be a liability of
the Employer or this Health FSA, provided an appropriate level of care shall have been exercised by the Employer in attempting to make such payment.

ARTICLE VII

Amendment and Termination

7.1 Amendment. The Employer has the right to amend this Health FSA at any time to the extent that it may deem advisable, subject to applicable law. Any amendment shall be at the direction of an authorized officer of the Employer or an authorized designee.

7.2 Termination. The Employer has established this Health FSA with the bona fide intention and expectation that it will be continued indefinitely, but the Employer is not and shall not be under any obligation or liability whatsoever to maintain this Health FSA for any given length of time and may, in its sole and absolute discretion, discontinue or terminate this Health FSA, in whole or in part, at any time, at the direction of an authorized officer of the Employer or an authorized designee.

ARTICLE VIII

Spendthrift Provision

A Participant’s rights to pay for benefits under the Plan with pre-tax compensation shall not be assignable or subject to attachment or receivership, nor shall they pass to any trustee in bankruptcy or be reached or applied by any legal process for the payment of any obligations of the Participant.

ARTICLE IX

Modification or Revocation of Elections

9.1 Limitations. A Participant’s pre-tax contribution election, as indicated on his or her Enrollment Form, shall remain in effect for the Period of Coverage unless modified or revoked by a Participant as provided in this Article. A Participant may modify or revoke an election with respect to the current Period of Coverage only in accordance with this Article IX.

9.2 Modification or Revocation of Election. An Eligible Employee may modify or revoke an election during a Plan Year within 30 days after the occurrence of one of the events described in this Section or, if longer, within the period required by applicable law, as follows:

(a) An Eligible Employee may modify or revoke an election during a Period of Coverage if one of the following “change in status events” occurs and the modification or revocation satisfies the consistency requirement of paragraph (b) below:

(i) a change in the Eligible Employee’s legal marital status, including marriage, death of a Spouse, divorce, legal separation or annulment;
(ii) a change in the number of the Eligible Employee’s Dependents, including due to the birth, adoption, placement for adoption, or death of a Dependent;

(iii) a change in employment status of the Eligible Employee, his or her Spouse, or a Dependent, including a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in worksite;

(iv) a Dependent satisfies or ceases to satisfy the requirements for coverage under this Plan;

(v) the Eligible Employee, his or her Spouse or Dependent changes his or her place of residence, but only if such change affects the person’s eligibility for coverage; or

(vi) Any other event that the Plan Administrator may determine will permit a change or revocation of an election in accordance with the rulings and regulations under Code Section 125.

(b) An Eligible Employee’s modification or revocation of his or her election during the Plan Year must be consistent with the change in status event, and thus permissible, only if the election change is on account of and corresponds with a change in status event that affects eligibility for coverage under the Plan or under a plan maintained by the Spouse’s or Dependent’s employer.

(c) If an Eligible Employee, his or her Spouse or Dependent becomes enrolled under Part A or Part B of Title XVIII of the Social Security Act (“Medicare”) or Title XIX of the Social Security Act (“Medicaid”) (other than coverage only for pediatric vaccines), the Participant may modify or revoke his or her Enrollment Form with respect to group health plan coverage to cancel coverage of the individual who becomes enrolled under Medicare or Medicaid. If the Eligible Employee, his or her Spouse or Dependent loses coverage described in the preceding sentence, the Eligible Employee may file a new Enrollment Form with respect to group health plan coverage in order to begin or increase coverage of that individual who lost coverage under Medicare or Medicaid.

(d) If an Eligible Employee, his or her Spouse or Dependent becomes eligible for continuation coverage as provided in the Consolidated Omnibus Budget Reconciliation Act (“COBRA”) and in Section 4980B of the Code, the Participant may modify his or her election to pay for the continuation coverage.

(e) An Eligible Employee who takes an unpaid leave of absence under the Family and Medical Leave Act of 1993 (“FMLA”) may revoke any and all existing elections at the beginning of (or during) the leave.

(f) Any modification or revocation of an election under this Section shall be effective at such time as the Plan Administrator shall prescribe, unless otherwise required by law.
ARTICLE X

Plan Administration and Fiduciary Duties

10.1 Named Fiduciary. The Plan Administrator shall be the “named fiduciary” of the Plan, as defined in Section 402(a)(2) of ERISA, unless the Employer appoints a replacement.

10.2 Plan Administration.

(a) The Plan Administrator shall have sole discretion and authority to control and manage the operation and administration of this Health FSA.

(b) The Plan Administrator shall have complete discretion to interpret the provisions of this Health FSA, make findings of fact, correct errors, and supply omissions. All decisions and interpretations of the Employer made in good faith pursuant to this Health FSA shall be final, conclusive and binding on all persons, subject only to the claims procedure, and may not be overturned unless found by a court to be arbitrary and capricious.

(c) The Plan Administrator shall have all other powers necessary to administer this Health FSA, including, but not limited to, the following:

(i) To prescribe procedures to be followed by Participants in filing claims under this Health FSA;

(ii) To prepare and distribute information explaining this Health FSA to Participants;

(iii) To receive from the Employer and Participants, Spouses, and Dependents such information as shall be necessary or desirable for the proper administration of this Health FSA;

(iv) To keep records of claims and disbursements for claims under this Health FSA, and such other information as may be required by the Code;

(v) To appoint individuals or committees to assist in the administration of this Health FSA and to engage any other agents it deems advisable;

(vi) To accept, modify or reject Employee enrollment under this Health FSA;

(vii) To promulgate Enrollment Forms and claims forms to be used by Participants;

(viii) To prepare and file any reports or returns with respect to this Health FSA required by the Code or any other laws;
(ix) To determine and enforce any limits on benefits elected hereunder;

(x) To correct errors and make equitable adjustments for mistakes made in the administration of this Health FSA; specifically, and without limitation, to recover erroneous overpayments made from the Plan to a Participant, Spouse, or Dependent, in whatever manner the Employer determines is appropriate, including suspensions or recoupment of, or offsets against, future payments due that Participant, Spouse, or Dependent.

10.3 Delegation of Duties. The Plan Administrator may delegate responsibilities for the operation and administration of this Health FSA, may designate fiduciaries other than those named in the Health FSA, and may appoint one or more claim administrators to process all or a designated portion of claims under this Health FSA in accordance with its terms. The person, persons, entity or entities serving as claim administrator shall serve at the pleasure of the Plan Administrator.

10.4 Fiduciary Duties and Responsibilities. Each Plan fiduciary shall discharge his or her duties with respect to the Health FSA solely in the interest of each Participant, Spouse, Dependent and Beneficiary; for the exclusive purpose of providing benefits to such individuals and defraying reasonable expenses of administering the Plan; and in accordance with the terms of the Health FSA. Each fiduciary, in carrying out such duties, shall act with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in exercising such authority. A fiduciary may serve in more than one fiduciary capacity. Unless liability is otherwise provided under Section 405 of ERISA, a named fiduciary shall not be liable for any act or omission of any other party to the extent that (a) such responsibility was properly allocated to such other party as a named fiduciary, or (b) such other party has been properly designated to carry out such responsibility pursuant to the procedures set forth above.

10.5 Nondiscrimination Rules. In accordance with the nondiscrimination provisions of Code Section 125, the Plan intends to not discriminate in favor of highly compensated individuals regarding eligibility, participation, contributions or benefits. In addition, highly compensated Participants (Participants who are described in Section 105(h)(5) of the Code) shall be required to include in their gross incomes for federal income tax purposes Health FSA reimbursements that are excess reimbursements as defined in Section 105(h) of the Code if the Plan fails to satisfy the nondiscrimination requirements of Section 105(h) of the Code with respect to eligibility or benefits. The Plan Administrator may take action as necessary to ensure that the Plan does not violate the nondiscrimination provisions of the Code.
ARTICLE XI

Miscellaneous

11.1 Limitation of Rights. Neither the establishment nor the existence of this Health FSA, nor any modification thereof, shall operate or be construed as to:

   (a) give any person any legal or equitable right against the Employer or Plan Administrator except as expressly provided herein or required by law, or

   (b) create a contract of employment with any Employee, obligate the Employer to continue the service of any Employee, or affect or modify the terms of an Employee’s employment in any way.

11.2 Benefits Solely from General Assets. The benefits provided hereunder will be paid solely from the general assets of the Employer. Nothing herein will be construed to require the Employer to maintain any fund or segregate any amount for the benefit of any Participant from the Employer’s general assets, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Health FSA may be made.

11.3 Governing Laws and Jurisdiction and Venue. This Health FSA shall be construed and enforced according to the laws of the state of Rhode Island, to the extent not preempted by federal law which shall otherwise control. Exclusive jurisdiction and venue of all disputes arising out of or relating to this Health FSA shall be in any court of appropriate jurisdiction in the state of Rhode Island.

11.4 Severability. If any provision of this Health FSA plan document is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provision of this Health FSA, and this Health FSA shall be construed and enforced as if such invalid or unenforceable provision had not been included herein.

11.5 Construction. The captions contained herein are inserted only as a matter of convenience and reference, and in no way define, limit, enlarge or describe the scope or intent of this Health FSA, nor in any way shall affect this Health FSA or the construction of any provision thereof. Any terms expressed in the singular form shall be construed as though they also include the plural, where applicable, and references to the masculine, feminine, and the neuter are interchangeable.

11.6 Titles. The titles of the Articles and Sections hereof are included for convenience only and shall not be construed as part of this Health FSA or in any respect affecting or modifying its provisions. Such words in this Health FSA as “herein,” “hereinafter,” “hereof” and “hereunder” refer to this instrument as a whole and not merely to the subdivision in which said words appear.
11.7 Expenses. All expenses incurred in establishing and operating this Health FSA, including, without limiting the generality of the foregoing, legal fees, accounting fees, administrative expenses and the like, shall be paid by the Employer.

ARTICLE XII

Participating Employers

12.1 Adoption of the Plan. This Health FSA may be adopted by a Participating Employer, provided that such adoption is with the approval of the Employer and meets the definition of a Participating Employer as described in Section 2.8. Such adoption shall be by resolution of the Participating Employer's governing body.

12.2 Administration. As a condition to adopting this Health FSA, and except as otherwise provided herein, each Participating Employer shall be deemed to have authorized the Plan Administrator to act for it in all matters arising under or with respect to the Plan and shall comply with such other terms and conditions as may be imposed by the Plan Administrator.

12.3 Termination of Participation. Each Participating Employer may cease to participate in this Health FSA with respect to its Employees or former Employees by resolution of its governing body.

ARTICLE XIII

Special Compliance Provisions

13.1 Use and Disclosure of Protected Health Information. Unless the Plan is self-administered and has fewer than 50 Participants, the Plan shall use protected health information ("PHI") only to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). For purposes of this Section, health plan shall have the meaning as defined in HIPAA. Specifically, any health plan shall use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations, as those terms are defined in HIPAA Regulation 45 C.F.R. § 164.501.

(a) A Plan will use and disclose PHI as required by law and as permitted by authorization of the Participant or other covered individual. With an authorization, a Plan shall disclose PHI to pension plans, disability plans, reciprocal benefit plans, and workers’ compensation insurers, for purposes related to administration of the Plan.

(b) A Plan shall disclose PHI to the Employer only upon receipt of a certification from the Employer that the Plan documents have been amended to incorporate the following provisions and that the Employer agrees to:

(i) not use or further disclose PHI other than as permitted or required by this Health FSA plan document or as required by law;
(ii) ensure that any agents, including subcontractors, to whom the Employer provides PHI received from a Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;

(iii) not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;

(iv) not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by an individual;

(v) report to the Plan’s designee any PHI use or disclosure that it becomes aware of which is inconsistent with the uses or disclosures provided for;

(vi) make PHI available to an individual in accordance with HIPAA’s access requirements;

(vii) make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(viii) make available the information required to provide an accounting of disclosures;

(ix) make the Employer’s internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services for the purposes of determining the Plan’s compliance with HIPAA;

(x) ensure that adequate separation between the Plan and the Employer is established as required by HIPAA; and

(xi) if feasible, return or destroy all PHI received from the Plan that the Employer 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 not feasible).

(c) Only those employees or classes of employees identified in the Plan’s privacy policies and procedures may have access to and use and disclose PHI for plan administration functions that the Employer performs for the Plan. If such individuals do not comply with this plan document, the Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

(d) Security. The Employer shall implement security measures with respect to PHI to the extent of and in accordance with the security rules implemented by HIPAA. Specifically, the Employer shall:

(i) implement administrative, physical and technical safeguards that will reasonably and appropriately protect the confidentiality, integrity, and availability of the
electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

(ii) ensure the adequate separation between the Plan and the Employer is supported by reasonable and appropriate security measures;

(iii) ensure that any agent, including a subcontractor, to whom it provides information agrees to implement reasonable and appropriate security measures to protect the information (e.g., in the event the Employer provides information to the broker for renewal bids); and

(iv) report to the Plan any security incident of which it becomes aware.

13.2 Family and Medical Leave Act of 1993 (“FMLA”). A Participant who takes an unpaid leave of absence under the Family and Medical Leave Act of 1993 (“FMLA”) may revoke his or her Enrollment Form election at the beginning of or during the leave. However, the Participant shall have the right to reinstate his or her election upon his or her return to work after the FMLA leave period. In addition, the Employer shall have the right to require Participants to resume participation in the Plan at the level previously elected on the Enrollment Form, if it requires Participants on other forms of leave to do so.

If a Participant chooses to continue coverage under the Employer’s group health plan during an unpaid leave of absence under FMLA, the Plan Administrator shall select among the following options for required payments during the leave of absence:

(a) Pre-payment by the Participant before the commencement of the leave through pre-tax or after-tax contributions under an Enrollment Form, from any taxable compensation, including cashing out of unused sick or vacation days, provided all other Plan requirements are met; provided, however, that pre-payment shall not be the sole option offered to a Participant on FMLA leave;

(b) Payment by the Participant of required payments during the leave on the same schedule as payments would be made if the Participant were not on leave, or under another schedule permitted under federal regulations. The Employer shall not be required to continue group health plan coverage of a Participant who fails to make required payments while on FMLA leave. However, if the Employer chooses to continue such coverage of a Participant who fails to make required payments while on FMLA leave, the Employer is entitled to recover those payments after the Participant returns from FMLA leave by payroll deduction; or

(c) Advancement by the Employer of the Participant’s required payments while the Participant is on FMLA leave. The Employer shall be entitled to recover such advanced amounts when the Participant returns from FMLA leave by payroll deduction.

13.3 Military Leave. In no event shall benefits available under this Plan during a period of qualified military leave be less generous than those benefits available during other comparable employer-approved leave periods (e.g., family and medical leave). Notwithstanding any
provision of this Plan to the contrary, contributions and benefits with respect to qualified military service shall be provided in accordance with the Uniform Services Employment and Reemployment Rights Act (“USERRA”) and the regulations thereunder.

13.4 COBRA. Notwithstanding any provision in this Plan to the contrary, a Participant, Spouse or Dependent who loses coverage under the Plan due to a qualifying event as defined in the Consolidated Omnibus Budget Reconciliation Act (“COBRA”) and Section 4980B of the Code shall be entitled, to the extent required by law, to elect to continue the same coverage he or she had on the day before the qualifying event. Qualified beneficiaries who elect to continue coverage may submit claims for Medical Care expenses incurred after the qualifying event and before the end of such COBRA continuation coverage.

However, limited COBRA coverage may be provided where the maximum COBRA premium equals or exceeds the maximum benefit available under this Health FSA for the year, in accordance with Code Section 4980B.

ARTICLE XIV
Effective Date

This plan document sets forth the terms of this Health FSA as in effect January 01, 2021.
IN WITNESS WHEREOF, the Employer has caused this document to be duly executed in its name and on its behalf as of the date set forth below.

Children's Friend and Service

By: ______________________________
Date: ______________________________

ATTEST:

_______________________________
APPENDIX A
Children's Friend AND SERVICE
HEALTH FLEXIBLE SPENDING ACCOUNT

PARTICIPATING EMPLOYERS

In addition to Children's Friend and Service, the following Participating Employers have adopted this Health FSA pursuant to Article XII, Section 12.1:

There are no other employers participating in this Health FSA.
Spanish:
Este folleto contiene un resumen en inglés de los derechos y beneficios de su plan bajo su Programa de Beneficio Social. Si encuentra alguna dificultad para entender cualquier parte de este folleto, póngase en contacto con su Administrador(a) del Plan. Para mayor información, por favor póngase en contacto con: (401) 276-4300
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This document, along with any other applicable benefit descriptions, is the summary plan description ("SPD") for the Health Flexible Spending Account ("Health FSA" or "the Plan") of Children's Friend and Service (the "Employer"). This document describes the Health FSA as in effect on January 01, 2021.

The Health FSA permits eligible Employees to elect to make pre-tax contributions to reimburse qualified Medical Care expenses incurred by eligible Employees and their family members.

Because the benefits you receive will be of importance to you and your family, you should retain this SPD as part of your permanent records. However, remember that it is only a summary. The SPD summarizes who is eligible for benefits and the nature of the benefits available. The SPD does not change the provisions of any benefit plan documents or any legal instrument related to the creation, operation, funding, or benefit payment obligations of the Health FSA.

For additional information, you should contact Benefits & Wellness Specialist at (401) 276-4300 or refer to the Health FSA plan document. Copies of the document are available from the Plan Administrator on request. If the terms of this SPD conflict with the plan document, the Health FSA plan document shall govern.

GENERAL PLAN INFORMATION

Type of Plan: Health Flexible Spending Account (FSA)

Plan Number: 501

Plan Year: The Plan Year is the twelve month period ending December 31.

Plan Sponsor: Children's Friend and Service (the “Employer”)  153 Summer Street  Providence, Rhode Island 02903  (401) 276-4300

For a list of Participating Employers, please refer to Appendix A.

Plan Sponsor’s Employer Identification Number: 05-0258819

Plan Administrator: Children's Friend and Service  153 Summer Street  Providence, Rhode Island 02903  (401) 276-4300
Agent for Service of Legal Process: Children's Friend and Service
153 Summer Street
Providence, Rhode Island 02903
(401) 276-4300

Service of legal process may also be made upon the Plan Administrator.

Claims Administrator: Health Equity
(866) 382-3510

ELIGIBILITY AND BENEFITS

This Health FSA is offered as a supplement to the Employer’s primary group health plan coverage. An Employee is generally eligible to participate in the Health FSA if he or she is eligible to enroll in the Employer’s primary group health plan.

The determination of an Employee’s eligibility to become and continue as a Participant in the Health FSA shall be made by the Plan Administrator based on the Plan Administrator’s records. The Plan Administrator’s eligibility determination shall be binding and conclusive. An Employee is eligible to participate in this Health FSA as follows:

<table>
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<th>Health Care Flexible Spending Account</th>
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<tr>
<td>Funding Medium</td>
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<tr>
<td>Self-Insured – The benefit is self-insured.</td>
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<td>Eligibility</td>
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<tr>
<td>Generally, employees who work an average of 30 hour(s) per week. Spouse Dependent/Child</td>
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<td>The above Participants must be eligible to enroll in the Employer's primary group health plan.</td>
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<td>An Employee is eligible to participate first of the month following date of hire.</td>
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<td>Plan coverage begins on the first day of the calendar month after the end of the Waiting Period.</td>
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<tr>
<td>Plan coverage will terminate at the end of the month in which the Employee terminates employment or is no longer an eligible Employee under the Plan’s provisions.</td>
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A Participant may elect a specific amount to be contributed via salary reduction, subject to applicable contribution limits prescribed by law, to pay for qualified Medical Care expenses incurred during the Plan Year by the Participant and the Participant’s Spouse and Dependents, if applicable. For purposes of this Health FSA, the term “Spouse” means an individual who is recognized as a Participant’s spouse under federal tax law. It does not include domestic partners. For purposes of this
Health FSA, the term “Dependent” means the Participant’s child(ren) if under age 27 as of the end of the taxable year.

The Employer may, at its sole discretion, contribute to a Participant’s Health FSA Benefits Account, subject to applicable limits.

REIMBURSEMENT RULES

The Health FSA will reimburse you for eligible “Medical Care” expenses, as defined by the Plan Administrator and in accordance with Code Section 213(d). Medical Care expenses may include: payments for medical services rendered by physicians, surgeons, dentists, and other medical practitioners; the costs of equipment, supplies, and diagnostic devices; the amounts you pay for transportation to get medical care; and health insurance co-pays and deductibles.

However, Medical Care expenses do not include health insurance premiums; long-term care services as defined in Code Section 7702B(c); or Medical Care expenses that have already been reimbursed, or are eligible to be reimbursed, by insurance or otherwise, among other exclusions. For expenses incurred prior to Jan. 1, 2020 (or later date, as established by the Plan Administrator), Medical Care expenses do not include amounts incurred for any medicine or drug (other than insulin) that is not “prescribed” within the meaning of Code Section 106(f).

The maximum amount of reimbursement from the Health FSA will be available at all times during the Period of Coverage. This means that a Participant’s entire Health FSA election will be available from the first day of the Plan Year to reimburse Medical Care expenses incurred during the Period of Coverage.

In general, to receive reimbursement, the expense must be substantiated. This may include providing a bill or receipt which includes the name and address of the service provider, the name and address of the Participant, and the name and date of birth of the person for whom the Medical Care expense was incurred.

Amounts remaining in a Participant’s Benefits Account at the end of the Plan Year shall be handled in the following manner:

A Plan Participant has an extra 3 months after the Plan Year has ended to use their rollover funds. This is known as a Grace Period. Once the Grace Period ends on March 15th, then all funds will be forfeited.

For further details regarding the rules, practices, and procedures for reimbursement, please contact the Plan Administrator.

ENROLLING IN THE PLAN

To enroll in the Health FSA, an eligible Employee must annually complete any Enrollment Form required by the Plan Administrator, and elect the amount of pre-tax contributions for the Period of Coverage. The Enrollment Form must be completed, executed, and returned to the Plan.
Administrator by the applicable deadline. Coverage will be effective as soon as administratively possible after the completed Enrollment Form is received by the Plan Administrator. The Period of Coverage generally runs from the beginning of the Plan Year (or your date of initial eligibility) through the end of the Plan Year and cannot be changed or revoked unless you experience a “Change in Status” Event (described below).

Except for the Change in Status Events rule, and, if applicable, periods of FMLA Leave (see below) there is no provision for stopping or starting payroll deduction contributions or changing the amount of deductions at different times throughout the year. A pro-rated amount of your contribution election can be deducted throughout the entire Plan Year.

Once you have enrolled in the Plan, you will not need to complete another election form during the Plan Year to continue participation unless you want to revoke or modify your election due to a Change in Status Event.

In general, if you cease to be a Participant due to termination of employment and are rehired within 30 days, then the election that was in effect prior to your termination of employment shall be reinstated. If you are rehired more than 30 days following termination of employment, then you shall be treated as a new Employee and be permitted to make a new election.

CHANGE IN STATUS EVENTS

As explained above, your election must remain in effect from the beginning of the Plan Year (or your date of initial eligibility) through the end of the Plan Year, unless you revoke or change your election due to a Change in Status Event. In accordance with IRS rules, when you experience certain specified changes in your status or your personal circumstances during a Plan Year, you can change your election by increasing or decreasing the amount you have deducted from your salary. Any change you make must be consistent with the Change in Status Event. Examples of a Change in Status Event include the following:

(i) a change in your legal marital status, including marriage, death of a Spouse, divorce, legal separation or annulment;

(ii) a change in the number of your children, including the birth, adoption, placement for adoption, or death of a child;

(iii) a change in your employment status or your Spouse’s or covered child’s change in employment, including a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in worksite; or

(iv) your child satisfies or ceases to satisfy the requirements for coverage (for example, due to attainment of a specified age).

These are just some examples of Change in Status Events that may entitle you to make a change in your election during a Plan Year. Please consult the Plan Administrator for other circumstances that may be permissible Change in Status Events.
You must inform the Plan Administrator and make the change in your election within 30 days after the event that results in a Change in Status Event. If you do not inform the Plan Administrator of your need to make such a change within that 30-day period, you will then have to wait until the next open enrollment period to make a change in your election.

Please consult the Plan Administrator for additional information or if you have questions about Change in Status Events.

**HIPAA PRIVACY ISSUES**

With the exception of Health FSAs with fewer than 50 Participants that are self-administered, HIPAA requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Health FSA’s Privacy Notice. If you have questions or complaints about the privacy of your health information, contact the Plan Administrator.

Neither this Health FSA nor the Employer will use or further disclose information that is protected by HIPAA (“protected health information”) except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Health FSA has required all of its business associates to also observe HIPAA’s privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

**HEALTH COVERAGE DURING UNPAID FMLA LEAVE**

If your Employer has at least 50 employees employed within 75 miles of your worksite and you take an approved unpaid leave of absence that qualifies as family and medical leave under the Family and Medical Leave Act of 1993 (FMLA), you may generally continue to receive the maximum payment or reimbursement amount available under this Health FSA for medical expenses for yourself, and your covered Spouse and Dependents (if applicable), incurred during such leave, if contributions are made for this period of absence in a manner prescribed by the Plan Administrator.

If you do not continue coverage under this Plan during FMLA leave, but you return to work before the expiration of FMLA leave, you will be reinstated in your benefit coverage in this Plan under the same conditions as if the leave had not occurred. However, in this instance, you will not be reimbursed for medical expenses incurred during FMLA leave and credits to your Health FSA Account may be pro-rated based on absence to the extent permitted by law.

Additional family and medical leave or sick leave rights may apply under state law. Please contact the Plan Administrator for further information.
UNIFORMED SERVICES REEMPLOYMENT RIGHTS

Your right to continued participation in this Health FSA during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (“USERRA”). Accordingly, if you are absent from work due to a period of active duty in the military you may elect to continue participation in this Plan. If the absence is for 31 or more days, the cost of continuation coverage may not exceed 102% of the full cost of your health coverage.

USERRA continuation coverage is considered alternative coverage for purposes of COBRA. Therefore, if you elect USERRA continuation coverage, COBRA coverage will generally not be available.

Benefits during a period of military leave must be as generous as benefits available to similarly situated employees on other employer-approved leaves of absence (e.g., family and medical leave).

COBRA CONTINUATION COVERAGE

A Participant, Spouse or Dependent who loses coverage under the Plan due to a qualifying event as defined in the Consolidated Omnibus Budget Reconciliation Act (“COBRA”) and in Section 4980B of the Code shall be entitled, to the extent required by law, to elect to continue the same coverage he or she had on the day before the qualifying event at their own expense. Qualified beneficiaries who elect to continue coverage may submit claims for Medical Care expenses incurred after the qualifying event and before the end of such COBRA continuation coverage. However, limited COBRA coverage under this Health FSA may be provided in certain circumstances.

CLAIMS PROCEDURES

The following claims procedures shall apply specifically to claims made under this Health FSA. To the extent that these procedures are inconsistent with the claims procedures contained in the policies, contracts, or other written materials for the Health FSA, the claims procedures in such other policies, contracts, or other written materials shall supersede these procedures as long as such other claims procedures comply with Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719.

BENEFIT DETERMINATIONS

The Health FSA will reimburse claims that are filed for payment of benefits after health care has been received. If your 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 group health plan on which the denial is based, and provide the claim appeal procedures.

**How to Appeal a Claim Decision**

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient’s name.
- The Plan identification number.
- The date(s) of health care service(s).
- The provider’s name.
- The reason(s) 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.

**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 may consult with, or seek the participation of, medical experts as part of the appeal resolution process. By filing an appeal, you consent to this referral and the sharing of pertinent health 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.

**APPEALS DETERMINATIONS**

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

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.

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 the Claims Administrator. Your second level appeal request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision.
The second 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 review of the first level appeal decision.

External Review

If you exhaust all internal appeals procedures, you may be entitled to an external review of your claim. Please consult the Plan Administrator or Claims Administrator for further details.

PLAN AMENDMENT OR TERMINATION

The Employer has established the Health FSA with the intention and expectation that it will be continued indefinitely, but the Employer is not and shall not be under any obligation to maintain the Plan for any given length of time. Subject to applicable law, the Employer may amend or terminate the Plan, in whole or in part, at any time.

CIRCUMSTANCES THAT MAY CAUSE LOSS OF BENEFITS

The Health FSA contains numerous restrictions on the type and amount of benefits payable and the circumstances when paid. You may lose coverage if the Employer terminates the Plan or amends it to reduce or eliminate your coverage. You may forfeit the right to benefits if, among other things:

- You revoke your election to participate;
- You terminate employment with the Employer;
- You fail to file benefits claims on a timely basis;
- You make fraudulent benefits claims;
- You cease to be an eligible Employee; or
- The Health FSA terminates.

If you terminate participation in the Plan for any reason, including, without limitation, termination of employment, retirement, reduction of hours, death, disability or leave of absence, you will continue to be entitled to payment or reimbursement of Health FSA benefits for eligible Medical Care expenses incurred during the Period of Coverage prior to the termination of participation, if you file a claim within 90 calendar days from the date you cease to be a Participant.

For further details, please contact the Plan Administrator.

RESPONSIBILITY FOR GOODS/SERVICES

The Employer does not guarantee and is not responsible for the nature or quality of the goods or services provided through any health care provider or program because these goods and services are provided by personnel and agencies outside of the control of the Employer.

NO GUARANTEE OF EMPLOYMENT
Nothing contained in this document nor the benefit documents gives you the right to be retained in the service of the Employer or interferes with the right of the Employer to discharge you or to terminate your service at any time.

STATEMENT OF ERISA RIGHTS

As a Participant in the Health FSA you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all Participants shall be entitled to:

Receive Information About Your Plan and Benefits

⇒ Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
⇒ Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
⇒ Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each Plan Participant with a copy of this summary annual report.

Continue Health Plan Coverage

Continue health care coverage if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Spouse or Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
APENDIX A
CHILDREN'S FRIEND AND SERVICE
HEALTH FLEXIBLE SPENDING ACCOUNT

PARTICIPATING EMPLOYERS

In addition to Children's Friend and Service, the following Participating Employers have adopted the Health FSA:

There are no other employers participating in the Health FSA.
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EXHIBIT A
CHILDERN’S FRIEND AND SERVICE PREMIUM CONVERSION PLAN BENEFIT OPTIONS
CHILDREN'S FRIEND AND SERVICE
PREMIUM CONVERSION PLAN

Children's Friend and Service (the “Employer”) hereby sets forth the Children's Friend and Service Premium Conversion Plan, as in effect January 01, 2021.

ARTICLE I

Purpose

The purpose of this Plan is to enable Eligible Employees to elect to receive part of their compensation in the form of pre-tax benefits. The Plan is intended to be a “cafeteria plan” as described in Section 125 of the Code, as amended, as well as any rulings and regulations promulgated thereunder.

This Plan is a “Welfare Program” offered under Children's Friend & Service (the “Welfare Plan”), and is incorporated therein by reference.

ARTICLE II

Definitions

2.1 “Beneficiary” means a beneficiary as defined under a Benefit Option.

2.2 “Benefit Contributions” means credits to the Benefits Account on behalf of a Participant pursuant to the Participant’s Participation Agreement.

2.3 “Benefit Option” means any benefit listed in Exhibit A and for which an Eligible Employee may elect to make pre-tax contributions pursuant to Article VI and Article XII of the Plan.

2.4 “Benefits Account” means an account maintained on the books of the Employer for each Participant in accordance with Article VII for the purpose of recording the Participant’s Benefit Contributions. A subaccount shall be established hereunder with respect to each Benefit Option elected by a Participant.

2.5 “Code” means the Internal Revenue Code of 1986, as amended from time to time.

2.6 “Dependent” means a dependent as defined under a Benefit Option. However, for purposes of any Benefit Option that provides medical benefits, Dependent shall also include a Participant’s children who have not attained age 26 (or such later age as determined by the Plan Administrator).

2.7 “Eligible Employee” means an Employee described in Section 3.1.
2.8 “Employee” means any person providing services to the Employer or Participating Employer as a common-law employee. Non-resident aliens, independent contractors and individuals designated by the Employer as temporary employees shall not be Employees for purposes of this Plan. Leased employees within the meaning of Sections 414(n)(2) and 414(o)(2) of the Code, and employees subject to collective bargaining agreements may be included in the definition of Employee only at the discretion of the Employer.

2.9 “Employer” means Children's Friend and Service, and any entity which succeeds to the business and assumes the obligations of the Employer hereunder.


2.11 “Participant” means an Eligible Employee who has satisfied the requirements of Article III, entered into a Participation Agreement in accordance with Article IV, and whose participation has not terminated in accordance with Section 4.5.

2.12 “Participating Employer” means the term as defined in the Welfare Plan.

2.13 “Participation Agreement” means an electronic or written agreement entered into pursuant to Article IV, whereby an Eligible Employee agrees to reduce his or her cash compensation for the applicable Period of Coverage in consideration for the provision of a Benefit Option selected by the Eligible Employee.

2.14 “Period of Coverage” means the Plan Year; provided, however, that with respect to a Participant who commences participation after the beginning of the Plan Year, the initial Period of Coverage shall run from the effective date of the Participant’s properly completed and executed Participation Agreement to the end of that Plan Year, and all subsequent Periods of Coverage shall be on the Plan Year basis; provided, further, that if a Participant modifies or revokes his or her Participation Agreement as permitted in Article VIII, a new Period of Coverage begins as of the effective date of such modification or revocation and shall run until the end of the Plan Year.

2.15 “Plan” means the Children's Friend and Service Premium Conversion Plan as set forth herein and as amended from time to time.

2.16 “Plan Administrator” means the Employer or such other individual, committee or firm as the Employer shall designate from time to time.

2.17 “Plan Year” means the twelve consecutive month period ending on December 31.

2.18 “Spouse” means the individual who is legally married to an Eligible Employee under applicable law. Notwithstanding anything to the contrary contained herein, the term “Spouse” shall include a same-sex spouse who is legally married under applicable law.
ARTICLE III

Eligibility

3.1 Service Required to Become an Eligible Employee. Subject to Section 3.2, an Employee is eligible to participate in the Plan if he or she is eligible for coverage under a Benefit Option and meets any additional requirements under the provisions of Section 3.2.

3.2 Eligible Classification. Notwithstanding Section 3.1, an Employee shall not be an Eligible Employee while he or she is a member of a classification of Employees which the Plan Administrator has designated as not currently eligible to participate in the Plan. The Plan Administrator may at any time and from time to time remove any one or more Employees or group(s) or class(es) of Employees from eligibility for participation in this Plan, provided that in no event shall any such removal reduce the amount theretofore credited to the Benefits Account of any Participant.

3.3 Determination of Eligibility by Plan Administrator. The determination of an Employee’s eligibility to become and continue as a Participant in the Plan shall be made by the Plan Administrator from the Employer’s or Participating Employer’s records, and the Plan Administrator’s determination shall be binding and conclusive upon all persons.

ARTICLE IV

Participation

4.1 Election to Participate. If an initial Participation Agreement is required by the Plan Administrator, an Eligible Employee who files a properly completed and executed Participation Agreement with the Plan Administrator shall have elected to participate in the Plan and to reduce his compensation by the amount necessary to provide the elected Benefit Option(s). An Eligible Employee entitled to participate in the Plan pursuant to Section 3.1 must file a properly completed and executed Participation Agreement with the Plan Administrator within 30 days of his or her date of hire, within 30 days of his or her otherwise becoming an Eligible Employee or within such other time period as determined by the Plan Administrator. Such Participation Agreement shall be binding for the Period of Coverage to which it applies and may not be modified or revoked by the Participant or by the Employer or Participating Employer, except as provided in Article VIII or Article X.

If an initial Participation Agreement is required by the Plan Administrator and an Eligible Employee does not enroll in the Plan when initially eligible, then he or she may enroll in the Plan as of the first day of a succeeding Plan Year by filing a properly completed and executed Participation Agreement with the Plan Administrator during an open enrollment period preceding such Plan Year. After initially eligible, an Eligible Employee may timely file a new properly completed and executed Participation Agreement with the Plan Administrator to enter the Plan during a Plan Year only in accordance with Article VIII.
4.2 Elections for Subsequent Plan Years. If an initial Participation Agreement is required by the Plan Administrator and a Participant fails to file a new properly completed and executed Participation Agreement for a subsequent Plan Year, the existing Participation Agreement shall remain in effect for such subsequent Plan Year. The Plan Administrator may, at its discretion, require Eligible Employees to file new properly completed and executed Participation Agreements during an open enrollment period in order to continue benefits under the Plan.

4.3 Elections For Rehires. If a terminated Eligible Employee is rehired by the Employer or Participating Employer as an Eligible Employee within 30 days of his or her termination date, the Eligible Employee’s Participation Agreement (if required) that was in effect on the day he or she terminated shall be reinstated. An Eligible Employee who is rehired as an Eligible Employee more than 30 days following termination of employment may file a new Participation Agreement (if required) with the Plan Administrator in accordance with Section 4.1.

4.4 Effective Date for Participation Agreements. If an initial Participation Agreement is required by the Plan Administrator, a Participation Agreement shall be effective as of the first day of the payroll period after the Eligible Employee files such properly completed and executed Participation Agreement with the Plan Administrator, or such later date as the Plan Administrator may prescribe, provided, however, that the effective date complies with applicable law.

4.5 Termination of a Participation Agreement. A Participation Agreement terminates on the earlier of:

(a) the end of the Plan Year, unless automatically reinstated in accordance with Section 4.2,

(b) the date the Participant revokes his or her Participation Agreement in accordance with Article VIII,

(c) the date the Participant terminates employment with the Employer or Participating Employer,

(d) the date the Participant ceases to be an Eligible Employee, or

(e) the date the Plan terminates in accordance with Article X.

ARTICLE V

Funding

The Employer shall contribute to the cost of the Benefit Option(s) provided under the Plan to the extent of, and pursuant to, each Participant’s Participation Agreement.
ARTICLE VI

Benefit Options

6.1 Benefit Options. The Benefit Option(s) available under the Plan for which an Eligible Employee may choose pre-tax contributions in lieu of cash compensation may include any or all of the plans or programs listed in Exhibit A which are Welfare Programs under the Welfare Plan which the Employer, in its sole discretion, may make available from time to time.

6.2 Controlling Documents. While the Participant’s election to make pre-tax contributions to pay for one or more Benefit Options may be made pursuant to this Plan, the Benefit Options will be provided not by this Plan but instead by the respective benefit plans or programs constituting the Benefit Option. Such benefit plans or programs, if and as implemented and in effect from time to time, shall be set forth in written instruments or in insurance policies or contracts which shall be filed with or attached as appendices or schedules to the Welfare Plan. The types and amounts of benefits available under each available Benefit Option, the requirements for coverage and receiving benefits under the Benefit Option, and the other terms and conditions pertaining thereto, shall be as set forth in the written instruments or in the insurance policies or contracts comprising the respective plans or programs.

ARTICLE VII

Contributions Towards Benefit Options

7.1 Benefit Contributions for Benefit Options. If a Participant elects a Benefit Option as identified in Exhibit A, the Participant’s cash compensation will be reduced by the amount the Participant specifies (subject to any applicable limits imposed by the Plan Administrator or otherwise), or by the amount the Plan Administrator specifies as the Participant’s cost of the Benefit Option, and an amount equal to the reduction will be credited to the appropriate subaccount established under the Participant’s Benefits Account. Amounts allocated to each such subaccount shall remain segregated in such subaccount and may not be commingled with or transferred to any other subaccount under any circumstances. Amounts credited to each subaccount shall be applied to the next premium, payment, or expense, or shall be reimbursed to the Participant, as specified under the relevant Benefit Option. The subaccount shall thereupon be debited and reduced to its new balance.

7.2 Payment for Benefits With After-Tax Contributions. Notwithstanding any other provision of this Plan, the Employer may maintain and offer to its Eligible Employees the opportunity to obtain coverage under any employee benefit plan, including, without limitation, Benefit Options, pursuant to the Eligible Employee’s agreement to pay for such coverage with after-tax employee contributions. If any Benefit Option covers domestic partners, the Participant shall pay for the cost of such Benefit Option elected on behalf of a domestic partner with after-tax contributions, unless permitted to use pre-tax dollars in accordance with applicable federal or state law.
7.3 Medical Care Plan Continuation Coverage. Nothing contained in this Plan is intended to limit or affect the rights, if any, of a Participant or his or her covered Spouse or Dependents to continuation of coverage under any group health plan sponsored by the Employer. Such rights to continuation of coverage shall be governed by the terms of such Benefit Option(s) and by applicable law.

ARTICLE VIII

Modification or Revocation of Participation Agreement

8.1 Limitations. A Participation Agreement shall remain in effect unless modified or revoked by a Participant as provided in this Article. An Eligible Employee may modify or revoke a Participation Agreement with respect to the current Period of Coverage only in accordance with Section 8.2 or, if applicable, Sections 8.3 to 8.5. For purposes of this Article, Spouse does not include domestic partners, unless recognized as such under federal law.

8.2 Modification or Revocation of Participation Agreement. If permitted under a particular Benefit Option, an Eligible Employee may modify or revoke a Participation Agreement during a Plan Year within thirty days after the occurrence of one of the events described in this Section or, if longer, within the period required by applicable law, as follows:

(a) An Eligible Employee may modify or revoke a Participation Agreement during a Plan Year with respect to the Benefit Option(s) under the Plan if one of the following “change in status events” occurs and the modification or revocation satisfies the consistency requirement of paragraph (b) below:

(i) a change in the Eligible Employee’s legal marital status, including marriage, death of a Spouse, divorce, legal separation or annulment;

(ii) a change in the number of the Eligible Employee’s Dependents, including due to the birth, adoption, placement for adoption, or death of a Dependent;

(iii) a change in employment status of the Eligible Employee, his or her Spouse, or a Dependent, including a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in worksite;

(iv) a Dependent satisfies or ceases to satisfy the requirements for coverage due to attainment of a specified age, student status, or any similar circumstance as provided in the applicable Benefit Option;

(v) the Eligible Employee, his or her Spouse or a Dependent changes his or her place of residence, but only if such change affects the person’s eligibility for coverage under a Benefit Option; or
(vi) Any other event that the Plan Administrator may determine will permit a change or revocation of an election in accordance with the rulings and regulations under Code Section 125.

(b) With respect to the Benefit Option(s) under the Plan, an Eligible Employee’s modification or revocation of his or her Participation Agreement during the Plan Year is consistent with the change in status event, and thus permissible, only if the election change is on account of and corresponds with a change in status event that affects eligibility for coverage under one of the Benefit Options or under a plan maintained by the Spouse’s or Dependent’s employer. A change in status event that affects eligibility under a Benefit Option or a plan maintained by the Spouse’s or Dependent’s employer shall include a change in status event that results in an increase or decrease in the number of an Eligible Employee’s family members or Dependents who may benefit from coverage under the Benefit Option(s). With respect to any group term life insurance or group disability insurance identified in Exhibit A, an election by an Eligible Employee to either increase or decrease coverage in response to a change in status event is deemed to correspond with that change in status.

(c) An Eligible Employee may modify or revoke his or her Participation Agreement with respect to the group health plans identified in Exhibit A if the modification or revocation results from and is consistent with a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order, as defined in Section 609(a) of ERISA) that requires group health plan coverage for the Eligible Employee’s child or foster child who is a dependent of the Eligible Employee. The Eligible Employee may modify or revoke his Participation Agreement during the Plan Year in order to:

(i) provide group health coverage for the child if the order requires coverage for the child under the Eligible Employee’s plan; or

(ii) cancel group health plan coverage for the child if the order requires the Spouse, former Spouse, or other individual to provide coverage for the child, and the coverage is, in fact, provided.

(d) If the Participant, his or her Spouse or Dependent becomes enrolled under Part A or Part B of Title XVIII of the Social Security Act (“Medicare”) or Title XIX of the Social Security Act (“Medicaid”) (other than coverage only for pediatric vaccines), the Participant may modify or revoke his or her Participation Agreement with respect to group health plan coverage to cancel coverage of the individual who becomes enrolled under Medicare or Medicaid. If an Eligible Employee, his or her Spouse or Dependent loses coverage described in the preceding sentence, the Eligible Employee may file a new Participation Agreement with respect to group health plan coverage in order to begin or increase coverage of that individual who lost coverage under Medicare or Medicaid.

(e) The Participant may modify or revoke his or her Participation Agreement with respect to a Benefit Option listed in Exhibit A (other than a health care flexible spending account plan), if there are significant cost increases or decreases charged to the Participant for
such Benefit Option. Permitted changes include: commencing participation in the Plan for a Benefit Option that decreases in cost, or, in the case of a Benefit Option that increases in cost, revoking an election for coverage and instead receiving, on a prospective basis, coverage under another Benefit Option providing similar coverage or dropping coverage if no such other Benefit Option providing similar coverage is available.

(f) If a Participant or a Participant’s Spouse or Dependent has a significant curtailment of coverage under a Benefit Option (other than a health care flexible spending account plan) during a Period of Coverage that is not a loss in coverage (e.g., a significant increase in the deductible, the required co-payments, or the out-of-pocket cost sharing limit under a group health plan), any Participant who had elected that Benefit Option may modify or revoke his or her election for that coverage and instead elect to receive, on a prospective basis, coverage under another Benefit Option providing similar coverage. Coverage under a Benefit Option is significantly curtailed only if there is an overall reduction in coverage provided under the Benefit Option so as to constitute reduced coverage generally. The loss of one particular physician in a health network is not a significant curtailment.

(g) If a Participant or a Participant’s Spouse or Dependent has a significant curtailment of coverage under a Benefit Option (other than a health care flexible spending account plan) during a Period of Coverage that is a loss in coverage, the Participant may modify or revoke his or her Participation Agreement under the Plan and instead elect either to receive on a prospective basis coverage under another Benefit Option providing similar coverage or to drop coverage if no similar Benefit Option is available. A loss of coverage means a complete loss of coverage under a Benefit Option, including the elimination of the Benefit Option or an HMO ceasing to be available in the area where the individual resides. For purposes of this paragraph, a loss of coverage also includes:

(i) a substantial decrease in medical care providers available under the Benefit Option;

(ii) a reduction in the benefits for a specific type of medical condition or treatment with respect to which the Participant, Spouse or Dependent is currently undergoing a course of treatment; or

(iii) any other similar fundamental loss of coverage.

(h) If the Plan adds a new Benefit Option (other than a health care flexible spending account plan) or if coverage under an existing Benefit Option (other than a health care flexible spending account plan) is significantly improved during a Period of Coverage, an Eligible Employee may modify or revoke his or her Participation Agreement with respect to that Benefit Option and, on a prospective basis, elect coverage under the new or improved Benefit Option.

(i) If an Eligible Employee’s Spouse or Dependent makes an election change under an applicable welfare plan or Section 125 plan maintained by such individual’s employer, the Eligible Employee may modify or revoke his or her Participation Agreement if the change is
on account of and corresponds with the election change made by the Eligible Employee’s Spouse or Dependent, provided that the Spouse or Dependent’s election change satisfies the regulations and rulings under Section 125 of the Code or the period of coverage under the other employer’s applicable welfare plan or Section 125 plan does not correspond to the Period of Coverage under this Plan.

(j) In the event that an Eligible Employee, his or her Spouse or Dependent loses group health coverage sponsored by a governmental or educational institution, the Eligible Employee may elect health coverage identified in Exhibit A for the balance of the Plan Year for the Eligible Employee, his or her Spouse or Dependent.

(k) An Eligible Employee may elect group health plan coverage listed in Exhibit A for the balance of the Plan Year for the Eligible Employee, his or her Spouse and/or Dependent if:

(i) The Employee’s, Spouse’s or Dependent’s Medicaid or Children’s Health Insurance Program (“CHIP”) coverage is terminated as a result of loss of eligibility and the Eligible Employee requests coverage under the group health plan listed in Exhibit A within 60 days after the termination, or

(ii) The Employee, Spouse or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP and the Eligible Employee requests coverage under the group health plan listed in Exhibit A within 60 days after eligibility is determined.

(l) The Participant may revoke his or her Participation Agreement, with respect to a group health plan identified in Exhibit A that provides minimum essential coverage as defined under the Patient Protection and Affordable Care Act of 2010, if the Participant has been in an employment status under which he or she was reasonably expected to average at least 30 hours of service per week and there is a change in that Participant’s status so that he or she will reasonably be expected to average less than 30 hours of service per week after the change (regardless of whether this results in the loss of eligibility for the current group health plan), provided that the revocation of the election of coverage corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

(m) The Participant may revoke his or her Participation Agreement, with respect to a group health plan identified in Exhibit A that provides minimum essential coverage, if the Participant is eligible for a special enrollment period to enroll in a qualified health plan through a Health Insurance Marketplace pursuant to guidance issued by the U.S. Department of Health and Human Services and any other applicable guidance, or the Participant seeks to enroll in a qualified health plan through a Health Insurance Marketplace during the Marketplace’s annual open enrollment period, provided that the revocation of the election of coverage corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in a qualified health plan through a Health Insurance
Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

(n) An Eligible Employee who otherwise is entitled to modify or revoke his or her Participation Agreement under (e) through (h) must do so within 30 days of receipt of written notice, from the Plan Administrator, of the significant change in cost or composition of the benefit originally elected. Accordingly, the Plan Administrator shall have the affirmative duty of providing Eligible Employees with written notification of such changes as soon as administratively feasible.

(o) Any modification or revocation of a Participation Agreement under this Section shall be effective at such time as the Plan Administrator shall prescribe, unless otherwise required by law.

8.3 Continuation Health Coverage. If the Employer so permits and the Participant, Spouse or Dependent becomes eligible for continuation coverage under a Benefit Option that is a group health plan in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”) or any similar state law, the Participant may elect to increase payments under such group health plan(s) to pay for continuation coverage.

8.4 Family and Medical Leave Act of 1993 (“FMLA”). A Participant who takes an unpaid leave of absence under FMLA may revoke his or her Participation Agreement at the beginning of or during the leave. Such a revocation is binding on the Participant for the balance of the Plan Year and may not be changed until the next Period of Coverage, except for a revoked election under a group health plan which the Participant shall have the right to reinstate at the end of the FMLA leave period.

If a Participant chooses to continue coverage under the Employer’s group health plan during an unpaid leave of absence under FMLA, the Plan Administrator shall select among the following options for required payments during the leave of absence:

(a) Pre-payment by the Participant before the commencement of the leave through pre-tax or after-tax payments under a Participation Agreement, from any taxable compensation, including cashing out of unused sick or vacation days, provided all other Plan requirements are met; provided, however, that pre-payment shall not be the sole option offered to a Participant on FMLA leave;

(b) Payment by the Participant of required payments during the leave on the same schedule as payments would be made if the Participant were not on leave, or under another schedule permitted under Department of Labor regulations. The Employer shall not be required to continue group health plan coverage of a Participant who fails to make required payments while on FMLA leave. However, if the Employer chooses to continue such coverage of a Participant who fails to make required payments while on FMLA leave, the Employer is entitled to recover those payments after the Participant returns from FMLA leave by payroll deduction; or
(c) Advancement by the Employer of the Participant’s required payments while the Participant is on FMLA leave. The Employer shall be entitled to recover such advanced amounts when the Participant returns from FMLA leave by payroll deduction.

8.5 Military Leave. (a) If a Participant’s absence for military duty is less than 31 days, the Participant will be required to pay the regular employee share of the cost for group health plan coverage in accordance with Section 8.4.

(b) Participants returning from military leave shall be reinstated upon re-employment.

(c) In no event shall benefits available under this Plan during a period of qualified military leave be less generous than those benefits available during other comparable employer-approved leave periods (e.g., family and medical leave).

ARTICLE IX

Claims Procedure

9.1 Written Claim for Benefits. If a Participant asserts a right to any benefit under the Plan which he or she has not received, the Participant must file a written claim for such benefit with the Plan Administrator (as defined in Section 2.16 of this plan document). If the Plan Administrator wholly or partially denies such claim, it shall provide written notice to the claimant within 90 days (or longer if the situation so requires but not longer than 180 days) of the receipt by the Plan Administrator of the application. The Plan Administrator shall set forth in the notice:

(a) the specific reason(s) for the denial of the claim,

(b) the specific reference to pertinent provisions of the Plan on which the denial is based,

(c) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary, and

(d) an explanation of the Plan’s claims review procedure.

9.2 Review of Denied Claim. A Participant whose application for benefits is denied, in whole or in part, may request a full and fair review of the decision denying the claim within 60 days after receipt of the notice of the denial from the Plan Administrator. The Participant may:

(a) request a hearing by the Plan Administrator upon written application to the Plan Administrator,

(b) review pertinent documents in the possession of the Plan Administrator, or
(c) submit issues and comments in writing to the Plan Administrator for review.

A decision on review by the Plan Administrator shall be made promptly but not later than 60 days after the receipt by the Plan Administrator of a request for review, unless special circumstances (such as the need to hold a hearing) require an extension of time for processing, in which case the claimant will be so notified of the extension, and a decision shall be rendered as soon as possible but not later than 120 days after the receipt of the request for review. The decision shall be in writing and shall include specific reasons for the decision written in a manner calculated to be understood by the Participant and specific reference to the pertinent provisions of the Plan on which the decision is based. The Plan Administrator’s decision shall be final and binding upon all parties.

9.3 Claims Under Benefit Options. The foregoing provisions of this Article describe the procedures for claiming the entitlements offered under this Plan, that is, salary reduction to enable Participants to pay their cost of Benefit Options with pre-tax income. A Participant or any Spouse, Dependent or Beneficiary shall make claims for actual benefits under the specific terms and claims review procedures of the Employer's benefit plans or programs which form the Benefit Option.

ARTICLE X

Amendment and Termination

10.1 Amendment. The Employer has the right to amend the Plan at any time to the extent that it may deem advisable, including the right to amend any of the Benefit Options or to transfer any Benefit Option(s) from the Plan into a separate, related plan. Any amendment shall be at the direction of an authorized officer of the Employer or an authorized designee.

10.2 Termination. The Employer has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but the Employer is not and shall not be under any obligation or liability whatsoever to maintain the Plan for any given length of time and may, in its sole and absolute discretion, discontinue or terminate the Plan, in whole or in part, at any time, including termination of any one or more of the Benefits Options, at the direction of an authorized officer of the Employer or an authorized designee.

ARTICLE XI

Spendthrift Provision

A Participant’s rights to pay for Benefit Options under the Plan with pre-tax compensation shall not be assignable or subject to attachment or receivership, nor shall they pass to any trustee in bankruptcy or be reached or applied by any legal process for the payment of any obligations of the Participant.
ARTICLE XII

Responsibilities of Participants

Each Participant shall be responsible for accurately reporting for tax purposes all taxable compensation received by him or her during each Plan Year. The Participant shall also be responsible for his or her portion of any additional income or Social Security taxes and for interest and penalties for the late payment of any taxes that may be owing in connection with any benefits paid under the Plan, and shall reimburse the Employer or Participating Employer for his or her portion of Social Security taxes and withholding taxes and for such interest and penalties, upon demand. Each Participant is responsible for the accuracy of all information and representations contained in any claim for benefits.

ARTICLE XIII

Administration and Fiduciary Provisions

13.1 Named Fiduciary. The Plan Administrator shall be the “named fiduciary” of the Plan, unless the Employer appoints a replacement.

13.2 Plan Administration.

(a) The Plan Administrator shall have sole discretion and authority to control and manage the operation and administration of the Plan.

(b) The Plan Administrator shall have complete discretion to interpret the provisions of the Plan, make findings of fact, correct errors, and supply omissions. All decisions and interpretations of the Plan Administrator made in good faith pursuant to the Plan shall be final, conclusive and binding on all persons, subject only to the claims procedure, and may not be overturned unless found by a court to be arbitrary and capricious.

(c) The Plan Administrator shall have all other powers necessary to administer the Plan, including, but not limited to, the following:

(i) To prescribe procedures to be followed by Participants in making elections under the Plan and in filing claims under the Plan;

(ii) To prepare and distribute information explaining the Plan to Participants;

(iii) To receive from the Employer (or Participating Employer) and Participants, Spouses, Dependents and Beneficiaries such information as shall be necessary or desirable for the proper administration of the Plan;
(iv) To keep records of elections, claims and disbursements for claims under the Plan, and such other information as may be required by the Code;

(v) To appoint individuals or committees to assist in the administration of the Plan and to engage any other agents it deems advisable;

(vi) To purchase any insurance deemed necessary for providing benefits under the Plan;

(vii) To accept, modify or reject Participant elections under the Plan;

(viii) To promulgate election forms and claims forms to be used by Participants;

(ix) To prepare and file any reports or returns with respect to the Plan required by the Code or any other laws;

(x) To determine and announce any Benefit Contributions required hereunder;

(xi) To determine and enforce any limits on benefits elected hereunder;

(xii) To take such action as may be necessary to effect any required payroll deduction of any Benefit Contributions required hereunder; and

(xiii) To correct errors and make equitable adjustments for mistakes made in the administration of the Plan; specifically, and without limitation, to recover erroneous overpayments made from the Plan to a Participant, Spouse, Dependent or Beneficiary, in whatever manner the Plan Administrator determines is appropriate, including suspensions or recoupment of, or offsets against, future payments due that Participant, Spouse, Dependent or Beneficiary.

13.3 Delegation of Duties. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan, may designate fiduciaries other than those named in the Plan, and may allocate or reallocate fiduciary responsibilities under the Plan.

13.4 Indemnification. The Plan Administrator and any delegate who is an employee of the Employer or Participating Employer shall be fully indemnified by the Employer or Participating Employer against all liabilities, costs and expenses (including defense costs, but excluding any amount representing a settlement unless such settlement is approved by the Employer or Participating Employer) imposed upon it in connection with any action, suit, or proceeding to which it may be a party by reason of being the Plan Administrator or having been assigned or delegated any of the powers or duties of the Plan Administrator, and arising out of any act, or failure to act, that constitutes or is alleged to constitute a breach of such person’s responsibilities in connection with the Plan, unless such act or failure to act is determined to be due to gross negligence or willful misconduct.
13.5 Fiduciary Duties and Responsibilities. Each Plan fiduciary shall discharge his or her duties with respect to the Plan solely in the interest of the Participants; for the exclusive purpose of providing benefits to such individuals and defraying reasonable expenses of administering the Plan; and in accordance with the terms of the Plan. Each fiduciary, in carrying out such duties, shall act with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in exercising such authority. A fiduciary may serve in more than one fiduciary capacity. Unless liability is otherwise provided under Section 405 of ERISA, a named fiduciary shall not be liable for any act or omission of any other party to the extent that (a) such responsibility was properly allocated to such other party as a named fiduciary, or (b) such other party has been properly designated to carry out such responsibility pursuant to the procedures set forth above.

13.6 Nondiscrimination Rules. If the Plan Administrator determines that there is non-compliance with any nondiscrimination rules required by the Internal Revenue Service, the Plan Administrator may take action to ensure compliance. These actions may include modification of elections by highly compensated employees, key employees, or other participants, or modifications of Employer contribution amounts.

ARTICLE XIV

Miscellaneous

14.1 Limitation of Rights. Neither the establishment nor the existence of the Plan, nor any modification thereof, shall operate or be construed as to:

(a) give any person any legal or equitable right against the Employer or Participating Employer except as expressly provided herein or required by law, or

(b) create a contract of employment with any Employee, obligate the Employer or Participating Employer to continue the service of any Employee, or affect or modify the terms of an Employee’s employment in any way.

14.2 Communication to Employees. The Employer or Participating Employer will from time to time notify all Employees of the availability and terms of the Plan.

14.3 Benefits Solely from General Assets. The benefits provided hereunder will be paid solely from the general assets of the Employer or Participating Employer. Nothing herein will be construed to require the Employer, Participating Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer or Participating Employer from which any payment under the Plan may be made.
14.4 **Governing Laws and Jurisdiction and Venue.** The Plan shall be construed and enforced according to the laws of the state of Rhode Island, to the extent not preempted by federal law which shall otherwise control. Exclusive jurisdiction and venue of all disputes arising out of or relating to this Plan shall be in any court of appropriate jurisdiction in the state of Rhode Island.

14.5 **Severability.** If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such invalid or unenforceable provision had not been included herein.

14.6 **Construction.** The captions contained herein are inserted only as a matter of convenience and reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof. Any terms expressed in the singular form shall be construed as though they also include the plural, where applicable, and references to the masculine, feminine, and the neuter are interchangeable.

14.7 **Titles.** The titles of the Articles and Sections hereof are included for convenience only and shall not be construed as part of this Plan or in any respect affecting or modifying its provisions. Such words in this Plan as “herein,” “hereinafter,” “hereof” and “hereunder” refer to this instrument as a whole and not merely to the subdivision in which said words appear.

14.8 **Expenses.** All expenses incurred in establishing and operating the Plan, including, without limiting the generality of the foregoing, legal fees, accounting fees, administrative expenses and the like, shall be paid by the Employer or Participating Employer.

**ARTICLE XV**

**Participating Employers**

15.1 **Adoption of the Plan.** This Plan may be adopted by a Participating Employer, provided that such adoption is with the approval of the Employer. Such adoption shall be by resolution of the Participating Employer’s governing body.

15.2 **Administration.** As a condition to adopting the Plan, and except as otherwise provided herein, each Participating Employer shall be deemed to have authorized the Plan Administrator to act for it in all matters arising under or with respect to the Plan and shall comply with such other terms arising under or with respect to the Plan and shall comply with such other terms and conditions as may be imposed by the Plan Administrator.

15.3 **Termination of Participation.** Each Participating Employer may cease to participate in the Plan or in any flexible benefits program with respect to its Employees or former employees by resolution of its governing body.
ARTICLE XVI

Effective Date

This plan document sets forth the terms of the Plan as in effect January 01, 2021.
IN WITNESS WHEREOF, the Employer has caused this document to be duly executed in its name and on its behalf as of the date set forth below.

Children's Friend and Service

By: ______________________________
Date: ______________________________

ATTEST:

_______________________________
The following Benefit Options are Welfare Programs which shall be treated as part of the Plan pursuant to Section 6.1 and as defined in Section 2.3:

**Welfare Programs**

**ASO Navigate GIL Mod $0**
Carrier’s or Benefit Option Administrator’s Name: Children's Friend and Service
Address: 153 Summer Street
Providence, Rhode Island 02903
(401) 276-4300

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

**Delta Dental PPO Plus Premier**
Carrier’s or Benefit Option Administrator’s Name: Delta Dental Of RI
Contract Number: 4160-0001
Address: PO Box 1517
Providence, Rhode Island 02901
(401) 752-6000
https://www.deltadentalri.com

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

**ASO Navigate GIL Mod $750**
Carrier’s or Benefit Option Administrator’s Name: Children's Friend and Service
Address: 153 Summer Street
Providence, Rhode Island 02903
(401) 276-4300

- Such other contracts as may, from time to time, replace any or all of the contracts listed above

**UnitedHealthcare Vision**
Carrier’s or Benefit Option Administrator’s Name: United Healthcare New England
Contract Number: 753421
Address: 475 Kilvert Street
Warwick, Rhode Island 02886
(888) 735-5842
• Such other contracts as may, from time to time, replace any or all of the contracts listed above

**Premium Conversion Plan**
Carrier’s or Benefit Option Administrator’s Name: Children's Friend and Service
Address: 153 Summer Street
Providence, Rhode Island 02903
(401) 276-4300

• Such other contracts as may, from time to time, replace any or all of the contracts listed above

Any other Benefit Option(s) which the Employer may make available hereunder in accordance with Section 125(f) of the Code.
CHILDREN’S FRIEND AND SERVICE
PREMIUM CONVERSION PLAN

SUMMARY PLAN DESCRIPTION

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This summary plan description ("SPD") describes the Children's Friend and Service Premium Conversion Plan (the “Plan”). Children's Friend and Service (the “Employer”) established the Plan to enable its employees to elect to reduce their compensation and make certain employee contributions on a pre-tax basis. This SPD explains how the Plan works, who administers it and the eligibility requirements. However, it is not the actual Plan. The actual Plan is a legal document which any employee may review and receive a copy upon request to the Plan Administrator. In the event of any conflict between any statements in this SPD and the provisions of the Plan, the provisions of the Plan will govern.

Plan records are maintained on the basis of the twelve-month period ending on December 31, which is called the "Plan Year."

Section 1. Purpose.

If you choose to participate in the Plan, you may elect to pay for one or more of the available “Benefit Options” (see Section 6 below) through pre-tax deductions from your compensation. Generally, the amount of your earnings that you elect to use to pay for your Benefit Options will not be subject to federal or state income tax or Social Security tax ("FICA").

The Plan is called a “Section 125 Plan” because, under Internal Revenue Code Section 125, it enables you to choose between cash compensation which is currently taxable to you and pre-tax contributions (within the limits permitted under the tax laws). You can decide which Benefit Options to choose. The Plan may also be referred to as a “cafeteria plan,” which means that it is operated to give you a choice among pre-tax contributions (e.g., for health care coverage) and after-tax cash compensation.

Section 2. How the Plan Works.

The Plan permits you to make pre-tax contributions to pay for certain “Benefit Options” for yourself and, if applicable, your spouse and eligible children. To use part of your cash compensation to purchase a Benefit Option under the Plan, you must complete and submit an election form required by the Plan Administrator, if you are not automatically enrolled. If required, the election form will indicate the Benefit Option or Benefit Options that you selected and the amount of money that will be deducted from your compensation to pay your share for those Benefit Options. The Employer deducts a pro-rated amount from each of your paychecks during the Plan Year.
Deducted amounts are credited to bookkeeping accounts maintained by the Employer in your name. Whenever you incur an expense which is covered by a Benefit Option you have elected, you must file a claim form in accordance with the procedures that apply to that Benefit Option.

Under current tax laws, amounts deducted from your cash compensation to purchase Benefit Options are generally not treated as taxable income. Therefore, when you use the Plan to pay for Benefit Options on a pre-tax, rather than on an after-tax basis, you should end up with more after-tax income to spend.

Contributions for coverage of eligible domestic partners are generally made on an after-tax basis.

Section 3. Eligible Employees.

All employees who are eligible for coverage under a Benefit Option are immediately eligible to participate in this Plan.

Section 4. How to Enroll in the Plan.

If you are not automatically enrolled in the Plan, you can enroll in the Plan by completing an election form for the Benefit Option(s) you have selected and filing the completed forms with the Plan Administrator on the date you first become eligible to enroll or during an open enrollment period before the beginning of the Plan Year. Coverage generally runs from the beginning of the Plan Year (or your date of initial eligibility) through the end of the Plan Year and cannot be changed or revoked unless you experience a “Change in Status” Event (described in Section 5 below).

Except for the Change in Status Events rule, there is no provision for stopping or starting payroll deductions or changing the amount of deductions at different times throughout the year. It is an IRS requirement that a pro-rated amount be deducted throughout the entire Plan Year.

Once you have enrolled in the Plan, you will not need to complete another election form for any subsequent Plan Year to continue participation unless you want to revoke or modify your election.

If you cease to be a participant due to termination of employment and are rehired within 30 days, then your election that was in effect prior to your termination of employment shall be reinstated. If you are rehired more than 30 days following termination of employment, then you shall be treated as a new employee.

Section 5. Change in Status Events.

As explained in Section 4 above, your election must remain in effect from the beginning of the Plan Year (or your date of initial eligibility) through the end of the Plan Year, unless you revoke or change your election due to a Change in Status Event. In accordance with IRS rules,
when you experience a significant change in your status or your personal circumstances during a Plan Year that affects your need or eligibility for a Benefit Option, you can change your election by increasing or decreasing the amount you have deducted from your salary, or you may elect a Benefit Option or discontinue one. Any change you make must be consistent with the Change in Status Event. Examples of a Change in Status Event include the following:

(i) a change in your legal marital status, including marriage, death of a spouse, divorce, legal separation or annulment;

(ii) a change in the number of your children, including due to the birth, adoption, placement for adoption, or death of a child;

(iii) a change in your employment status or your spouse’s or covered child’s change in employment, including a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in worksite;

(iv) your child satisfies or ceases to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance as provided in the plan under which you receive coverage;

(v) you and/or your spouse or covered child has a change of residence; or

(vi) your spouse or covered child makes an election change during an open enrollment period under his or her employer’s cafeteria plan, but only if the change under this Plan is consistent with and on account of your spouse’s or covered child’s change.

These are just some examples of Change in Status Events that may entitle you to make a change in your election during a Plan Year. Please consult the Plan Administrator for other circumstances that may be permissible Change in Status Events.

You must inform the Plan Administrator and make the change in your election within 30 days after the event that results in a Change in Status Event. If the Change in Status Event is the birth, adoption or placement for adoption of a child, then the effective date of the enrollment or change in election is the date of the child’s birth, adoption or placement for adoption. If you do not inform the Plan Administrator of your need to make such a change within that 30-day period, you will then have to wait until the next open enrollment period to make a change in your election.

Please consult the Plan Administrator for additional information or if you have questions about Change in Status Events.

Under the terms of the Plan, the Employer is authorized to offer you a salary reduction to pay for certain “Benefit Options” with pre-tax income as an alternative to cash compensation. These “Benefit Options” may change from time to time, depending on changes in the tax laws and other factors. The Benefit Options currently available to you under the Plan are as follows:

- ASO Navigate GIL Mod $0
- Delta Dental PPO Plus Premier
- ASO Navigate GIL Mod $750
- UnitedHealthcare Vision

Other Plans – Other benefit plans may be added as Benefit Options in the future. If any other plans are added, you will receive written notice of the terms for participation in these plans.


If you believe that you are not receiving credit for the proper contribution amount, you must file a written claim with the Plan Administrator setting forth the nature of the claim and the relief or correction sought. The Plan Administrator will respond to the claim within 90 days of its receipt (unless special circumstances require an extension). This procedure does not apply to Benefit Options available under the Plan. To file a written claim for benefits under one of the Benefit Options, you should refer to the summary plan description for such Benefit Option or contact the Plan Administrator.

If your claim is denied in whole or in part, you will receive a written notice from the Plan Administrator setting forth the specific reasons for the denial, specific reference to the pertinent provisions of the Plan on which the denial is based, a description of any additional material or information necessary for the claim to be approved, and a description of the claims review procedure under the Plan.

You are entitled to have the denial reviewed again by the Plan Administrator and, in connection with that review, you or your representative is entitled to examine all Plan documents and submit issues and comments in writing. If you want the Plan Administrator to review the denial, you must inform the Plan Administrator in writing within 60 days after you receive the Plan Administrator's notice of denial. The Plan Administrator will inform you in writing of the final decision and the specific reasons for that decision within 60 days of your request for review (unless special circumstances justify a delay).

Section 8. Plan Amendment or Termination.

The Employer expects to maintain the Plan indefinitely but reserves the right to amend or terminate the Plan if the Employer believes the situation so requires. If you have elected to participate in the Plan, you will be notified in writing if there is any significant amendment or if the Plan is terminated. If the Plan is terminated, the Employer will cease deducting contributions
from your salary to pay for Benefit Options. However, all previous salary deductions will be used to pay for Benefit Options.

Section 9. Miscellaneous Information.

Type of Plan: The Plan is a cafeteria plan intended to qualify under Section 125 of the Internal Revenue Code.

Plan Year: The Plan Year is the twelve month period ending December 31.

Plan Sponsor: Children's Friend and Service
153 Summer Street
Providence, Rhode Island 02903
(401) 276-4300

Plan Sponsor's Identification Number: 05-0258819

Plan Administrator: Children's Friend and Service
153 Summer Street
Providence, Rhode Island 02903
(401) 276-4300

Agent for Service of Legal Process: Children's Friend and Service
153 Summer Street
Providence, Rhode Island 02903
(401) 276-4300

Service of legal process may also be made upon the Plan Administrator.

For Questions Please Call: Children's Friend and Service
153 Summer Street
Providence, Rhode Island 02903
(401) 276-4300
UnitedHealthcare Insurance Company

Vision Certificate of Coverage

Issued To: Children’s Friend (“Enrolling Group”)
Policy Number: 753421
Policy Effective Date: January 1, 2019
Policy Anniversary Date: January 1

This Certificate of Coverage (“Certificate”) explains your rights and obligations as a Covered Person. It is important that you READ YOUR CERTIFICATE CAREFULLY.

The Policy may require that you contribute to the required Premiums. You can get any information about the Premium and the part you must pay from the Enrolling Group.

We agree with the Enrolling Group to provide Coverage for Vision Services to Covered Persons. This coverage is subject to the:

1. terms;
2. conditions;
3. exclusions; and
4. limitations

of the Policy.

We will not be considered an employer for any purpose with respect to administering or providing benefits under this benefit plan. We will not be responsible for fulfilling any duties or obligations of an employer with respect to this benefit plan.

The Policy will take effect on the date shown in the Policy. It will be continued in force by the payment of the required Policy Charges when they are due. This is subject to termination of the Policy as provided. All Coverage under the Policy will begin at 12:01 a.m., and end at 12:00 midnight at the Enrolling Group’s address.

The Policy is delivered in and governed by the laws of the State of Rhode Island.
Introduction to Your Certificate

You are eligible for Coverage under the Policy. Coverage is only available if the required Premiums for the Policy are paid. The Policy is referred to in this Certificate as the "Policy".

Coverage is subject to the Policy:

1. terms,
2. conditions,
3. exclusions, and
4. limitations.

As a Certificate, this document describes the provisions of Coverage under the Policy. This Certificate does not constitute the entire Policy. You may examine the entire Policy at the office of the Enrolling Group.

For Vision Services received after the effective date of the Policy, this Certificate will replace any other Certificate that we may have issued to you before this. Any Certificates that we may issue to you in the future will replace this one.

The employer expects to continue the group plan indefinitely. However, the employer reserves the right to change or end it at any time. This would change or end the terms of the Policy in effect at that time for active employees.

How To Use This Certificate

Read your Certificate carefully. Many of the provisions of this Certificate and the attached Schedule of Covered Vision Services are related to each other. Reading just one or two provisions may not give you the right impression of your Coverage.

Your Certificate and Schedule of Covered Vision Services may be changed by the attachment of Riders and/or Amendments. Please read the provisions described in your documents to determine how they may have changed.

Many words used in this Certificate and Schedule of Covered Vision Services have special meanings. These words will appear capitalized and are defined in Section 1: Definitions. Reviewing these definitions will give you a better understanding of your Certificate and Schedule of Covered Vision Services.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in Section 1: Definitions.

From time to time, the Policy may be amended. When that happens you will receive a new:
1. *Certificate*;
2. *Schedule of Covered Vision Services*;
3. Amendment pages for this *Certificate*; and/or
4. Amendment pages for the *Schedule of Covered Vision Services*.

Keep your *Certificate* and *Schedule of Covered Vision Services* in a safe place.

This *Certificate* may be amended at any time by applicable state or Federal laws, rules and regulations. These laws and the rules and regulations published under them, control and supersede this *Certificate*.

We have the authority to interpret the benefits Covered under the Policy. This includes the:

1. terms,
2. conditions,
3. limitations; and
4. exclusions

that are set out in the Policy.
Contact Us
Please contact us at 1-800-638-3120 if you have any questions regarding your benefits.
Group Vision Care Certificate of Coverage

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Section 1: Definitions

This Section defines the terms used throughout this Certificate and Schedule(s) of Covered Vision Services. It is not intended to describe Covered or uncovered services.

**Amendment** - any attached description of additional or alternative provisions to the Policy. Amendments are effective only when signed by an officer of the Company. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those which are specifically amended.

**Civil Union** - means a legal union between two individuals of the same sex. Persons shall be eligible to enter into a civil union only if both such persons are:

1. At least eighteen (18) years of age;
2. Of the same sex;
3. Not a party to another civil union or a spouse in a marriage with any other person;
4. Not in a family relationship; and
5. Neither person is mentally incompetent at the time of the civil union.

**Copayment** - the charge that you are required to pay to a Network Provider for certain Services payable under the Policy. You are responsible for the payment of any Copayment. This payment is made directly to the provider of the Service at the time of service, or when billed by the provider.

**Coverage or Covered** - the entitlement by a Covered Person to reimbursement for expenses incurred for Vision Services Covered under the Policy. Reimbursement is subject to the:

1. terms;
2. conditions;
3. limitations; and
4. exclusions of the Policy.

Vision Services must be provided:

1. when the Policy is in effect; and
2. prior to the date that any of the individual termination conditions as stated in Section 3: Termination of Coverage occur; and
3. only when the recipient is a Covered Person and meets all eligibility requirements specified in the Policy.

**Covered Person** - either the Subscriber or an Enrolled Dependent, while Coverage of such person under the Policy is in effect. References to you and your throughout this Certificate are references to a Covered Person.
Dependent:

! The Subscriber's legal spouse or Civil Union Partner. All references to the spouse of a Subscriber shall include a Domestic Partner; or

! A dependent child of you or your spouse. This includes:
  - A natural child;
  - A stepchild;
  - A legally adopted child;
  - A child placed for adoption; or
  - A child for whom the Subscriber or the Subscriber's spouse has legal guardianship.

The definition of "Dependent" is subject to the following conditions and limitations:

A. The term "Dependent" will not include any unmarried dependent child 26 years of age or older.

You agree to reimburse us for any Services provided to the child if the child did not satisfy these conditions.

The term "Dependent" also includes a child for whom vision care coverage is required:
  - through a Qualified Medical Child Support Order, or
  - through another court or administrative order.

The Enrolling Group will determine if a child meets the criteria of a Qualified Medical Child Support Order.

The term "Dependent" does not include anyone who is also a Subscriber. The term Dependent cannot be a "Dependent" of more than one Subscriber.

Domestic Partner - a person of the opposite or same sex with whom the Subscriber has established a Domestic Partnership. In no event will a person's legal spouse be considered a Domestic Partner.

Domestic Partnership - a relationship between the Subscriber and one other person of the opposite or same sex. The following requirements apply to both persons:

! They share the same permanent residence and the common necessities of life;
! They are not related by blood or a degree of closeness which would prohibit marriage in the law of the state in which they reside;
! Each is at least 18 years of age;
! Each is mentally competent to consent to contract;
Neither is currently married to, or Domestic Partner of, another person under either a statutory or common law;

They are financially interdependent and have furnished at least two of the following documents evidencing such financial interdependence:

- have a single dedicated relationship of at least 6 months duration;
- joint ownership of residence;
- at least two of the following:
  - joint ownership of an automobile;
  - joint checking, bank or investment account;
  - joint credit account;
  - lease for a residence identifying both partners as tenants;
  - a will and/or life insurance policies which designates the other as primary beneficiary.

The Subscriber and Domestic Partner must jointly sign an affidavit of Domestic Partnership;

They meet the requirements established by your Enrolling Group.

**Eligible Person** - an employee or member of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy.

**Enrolled Dependent** - a Dependent who is properly enrolled for Coverage under the Policy.

**Enrolling Group** - the employer or other defined or otherwise legally constituted group to whom the Policy is issued.

**Essential Health Benefits** - pediatric vision care services included as Essential Health Benefits as set forth in the Patient Protection and Affordable Care Act.

**Experimental, Investigational or Unproven Services** - services include:

- medical,
- dental,
- surgical,
- diagnostic, or other health care services,
- technologies,
- supplies,
treatments,
procedures,
drug therapies or
devices that, at the time we make a determination regarding Coverage in a particular case, are determined to be:

- 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; or
- Subject to review and approval by any institutional review board for the proposed use; or
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- Not demonstrated through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Foreign Services - services provided outside the U.S. and U.S. territories.

Initial Eligibility Period - the initial period of time, determined by us and the Enrolling Group, during which Eligible Persons may enroll themselves and Dependents under the Policy.

Medicare - Parts A, B, and C 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.

Network - the collective group of Vision Providers who are subject to a participation agreement in effect with us directly or through another entity, to provide Vision Services to you. The participation status of providers will change from time to time. The participation status of the provider may change based on the location where Vision Services were provided.

Network Benefits - benefits available for Covered Vision Services when provided by a Vision Provider who is a Network Vision Provider.

Non-Network - a Vision Provider who is not a participant in the Network.

Non-Network Benefits - Coverage available for Vision Services obtained from Non-Network Vision Providers.

Open Enrollment Period - after the Initial Eligibility Period, a period of time determined by us and the Enrolling Group, during which Eligible Persons may enroll themselves and Dependents under the Policy.
Party to a Civil Union - means a person who has established a civil union relationship.

Physician - any Doctor of Medicine, M.D., or Doctor of Osteopathy, D.O., who is duly licensed and qualified under the law of jurisdiction in which treatment is received.

Policy - The following forms constitute the agreement regarding the benefits, exclusions, and other conditions between the Enrolling Group and us:

1. The group Policy;
2. The application of the Enrolling Group;
3. Amendments; and
4. Riders.

Premium - the periodic fee required to maintain Coverage of Covered Persons in accordance with the terms of the Policy.

Rider - any attached description of Vision Services Covered under the Policy. Vision Services provided by a Rider may be:

1. Subject to payment of additional Premiums
2. Subject to additional Copayments

Riders are effective only when signed by an officer of the Company. Riders are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended.

Subscriber - an Eligible Person who is properly enrolled for Coverage under the Policy. The Subscriber is the person who is not a Dependent on whose behalf the Policy is issued to the Enrolling Group.

Vision Provider - any optometrist, ophthalmologist, or other person who may lawfully provide services to Covered Persons participating in our vision plans.

Vision Service - any Covered benefit listed in Section 8: Covered Vision Services.
Section 2: Eligibility and Effective Date of Coverage

Enrollment

Eligible Persons may enroll themselves and their Dependents for Coverage under the Policy during the Initial Eligibility Period or during an Open Enrollment Period. Enrollment is done by completing information provided by the Enrolling Group. Newly Eligible Persons and new Dependents may be enrolled as described below. Dependents of an Eligible Person may not be enrolled unless the Eligible Person is also enrolled for Coverage under the Policy.

If both spouses are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be Covered as an eligible Dependent of the other, but not both. If both parents of an eligible Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

Effective Date of Coverage

There is no Coverage for Vision Services rendered or delivered before the Policy Effective Date of Coverage.

If an Eligible Person enrolls during the Initial Eligibility Period, Coverage is effective on the first day of the month following any applicable waiting period required by the Enrolling Group.

Coverage for a Newly Eligible Person

Coverage for you and any of your Dependents will take effect on the date agreed to by the Enrolling Group and us. Coverage is effective only if we receive any required Premium. The Premium and enrollment form must be received within 31 days of the date you first become eligible.

Coverage for a Newly Eligible Dependent

Coverage for a new Dependent acquired by the following reasons will take effect on the date of the following event:

A. Birth,
B. Legal adoption,
C. Legal guardianship,
D. Placement for adoption,
E. Court or administrative order, or
F. Marriage or partnership into a Civil Union.
Coverage for a newborn child is provided for 31 days. If payment of additional Premium is required to provide Coverage for the child, the Company must receive the required Premium and be notified of the birth within 31 days after the birth in order to have the Coverage continue beyond the 31 day period. Coverage for all other new Dependents is effective only if we receive any required Premium and are notified of the event within 31 calendar days.

**Change in Family Status**

You may make Coverage changes during the year for any Dependent whose status as a Dependent is affected by the following events, as required by federal law:

A. Marriage or partnership into a Civil Union,
B. Divorce,
C. Legal separation,
D. Annulment,
E. Birth,
F. Legal guardianship,
G. Placement for adoption, or
H. Adoption.

In such cases, you must submit the required contribution of coverage and a properly completed enrollment form. The submission must be within 31 days of the:

A. Marriage or partnership into a Civil Union,
B. Birth,
C. Placement for adoption, or
D. Adoption.

Otherwise, you will need to wait until the next annual Open Enrollment Period.

**Special Enrollment Period**

An Eligible Person and/or Dependent who did not enroll for Coverage under the Policy during the Initial Eligibility Period or Open Enrollment Period may enroll for Coverage during a special enrollment period. A special enrollment period is available if the following conditions are met:

A. The Eligible Person and/or Dependent had existing health coverage under another plan at the time of the Initial Eligibility Period or Open Enrollment Period; and
B. Coverage under the prior plan was terminated because of loss of any of the following:
1. Eligibility (including, without limitation, legal separation, divorce or death),
2. Termination of employer contributions, or
3. In the case of COBRA continuation coverage, the coverage was exhausted.

A special enrollment period is not available if coverage under the prior plan was terminated for cause. It is also not available if coverage terminated because of failure to pay Premiums on a timely basis. Coverage under the Policy is effective only if we receive any required Premium and properly completed enrollment information. The Premium and enrollment form must be submitted within 31 calendar days of the date coverage under the prior plan terminated.

A special enrollment period is also available for an Eligible Person and for any Dependent whose status as a Dependent is affected by any of the following, as required by federal law:

1. Marriage or partnership into a Civil Union,
2. Birth,
3. Placement for adoption, or
4. Adoption.

In these cases, you must submit the required Premium and properly completed enrollment information. The Premium and enrollment form must be submitted within 31 calendar days of the:

1. Marriage or partnership into a Civil Union,
2. Birth,
3. Placement for adoption; or
4. Adoption.
Section 3: Termination of Coverage

Conditions for Termination of a Covered Person’s Coverage Under the Policy

We may, at any time, discontinue this benefit plan and/or all similar benefit plans for the reasons specified in the Policy.

Your Coverage will automatically terminate on the earliest of the dates specified below. This includes Coverage for Vision Services rendered after the date of termination for vision conditions arising prior to the date of termination.

A. The date the entire Policy is terminated, as specified in the Policy. The Enrolling Group is responsible for notifying you of the termination of the Policy.

B. The last day of the calendar month in which you cease to be eligible as a Subscriber, Enrolled Dependent or active member of the Policyholder.

C. The end of the month in which the Dependent child attains the limiting age.

D. The date we receive written notice from either the Subscriber or the Enrolling Group instructing us to terminate Coverage of the Subscriber or any Covered Person or the date requested in such notice, if later.

E. The date the Subscriber is retired or pensioned under the Enrolling Group’s Plan. This does not apply if a specific Coverage classification is specified for retired or pensioned persons in the Enrolling Group’s application and the Subscriber continues to meet any applicable eligibility requirements.

When any of the following apply, we will provide written notice of termination to the Subscriber.

F. The date specified by us that all Coverage will terminate due to fraud or misrepresentation or because the Subscriber knowingly provided us with false material information, including, but not limited to, false material information relating to residence, information relating to another person’s eligibility for Coverage or status as a Dependent. We have the right to rescind Coverage back to the Policy Effective Date. No statement made by the Subscriber will be used to void this Policy after it has been in force for a period of 2 years.

G. The date specified by us that all Coverage will terminate because the Subscriber:

   • permitted the use of his or her proof of Coverage by any unauthorized person or
   • used another person’s proof of Coverage.

H. The date specified by us that Coverage will terminate due to material violation of the terms of the Policy.
I. The date specified by us that your Coverage will terminate because you failed to pay a required Premium.

J. The date specified by us that your Coverage will terminate because you have committed acts of physical or verbal abuse, which pose a threat to our staff, a provider, or other Covered Persons.

**Coverage for a Disabled Dependent Child**

Coverage for an unmarried Enrolled Dependent child who is disabled 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:

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

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless Coverage is otherwise terminated in accordance with the terms of the Policy.

We will ask you to furnish us with proof of the medical certification of disability within 31 calendar days of the date Coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of Coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. 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 disability and dependency within 31 calendar days of our request as described above, Coverage for that child will end.

**Payment and Reimbursement Upon Termination**

Termination of Coverage will not affect any request for reimbursement for Vision Services that were rendered prior to the effective date of termination. Your request for reimbursement must be furnished as required in Section 4: Reimbursement.
Section 4: Reimbursement

Reimbursement for Services
The Covered Person will be responsible for any claims paid by us when Coverage was provided in error, except where that error was made by us. We will reimburse you for Eligible Expenses subject to the:

1. terms,
2. conditions,
3. exclusions, and
4. limitations

of the Policy and as described below.

Payment of Claims
When obtaining Vision Services from a Network Vision Provider, you will be required to pay a Copayment and any charges not Covered by the Policy to your Vision Provider. When obtaining Services from a Network Vision Provider, you will not be required to submit a claim form.

When obtaining Vision Services from a Non-Network Vision Provider, you will be required to pay all billed charges to your Vision Provider. You may then obtain reimbursement from us for the Covered portion of Vision Services.

Filing Claims for Reimbursement
You are responsible for submitting a request in writing for reimbursement to our office. Requests for reimbursement should be submitted within 90 calendar days after the date of service. Unless you are legally incapacitated, failure to provide this information to us within 365 calendar days from the date of service will cancel or reduce Coverage for the Vision Service.

Claim Forms. It is not necessary to include a claim form with the proof of loss. However, the proof of loss that you submit to us must include all of the following information:

! Your name and address; and
! Patient’s name and age; and
! Your identification number; and
! The name and address of the provider(s) of the service(s); and
! Itemized bill which includes a description of each charge; and
A statement indicating that you are or you are not enrolled for coverage under any other health or vision insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

If you would like to use a claim form, you may access a form on the Internet at www.myuhcvision.com or call us at 1-800-638-3120. A claim form will be provided to you. If you do not receive the claim form within 15 calendar days of your request, send in the proof of loss with the information stated above to Claims Department, PO Box 30978, Salt Lake City, UT 84130 or by fax to 248-733-6060.

**Proof of Loss.** Written proof of loss should be given to us within ninety (90) calendar days after the date of the loss. If it was not reasonably possible to give written proof in the time required, we will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible. In no event, except in the absence of legal capacity of the claimant, should it be filed later than one (1) year from the time proof is otherwise required.

**Payment of Claims.** Benefits are payable not more than 60 days after we receive acceptable proof of loss. Benefits will be paid to you unless:

A. The Vision Provider notifies us that your signature is on file assigning benefits directly to that Vision Provider; or

B. You make a written request at the time the claim is submitted.

All or a portion of any Eligible Expenses due may be paid directly to the Vision Provider who provided the Vision Services instead of being paid to the Subscriber. This is subject to written authorization from a Subscriber.

**Obtaining Services**

To find a Network Vision Provider, you may access a listing of Network Vision Providers on the Internet at www.myuhcvision.com. You may also call the UnitedHealthcare Provider Locator Service at 1-800-839-3242.

You also may obtain Services from a Non-Network Vision Provider. However, the amount of Coverage may be reduced.

**Foreign Services**

Foreign Services will be treated as Non-Network Benefits under this Policy. Payments will be made in U.S. currency and dispersed to the U.S. address of the Subscriber. We make no guarantee on value of payment and will not protect against currency risk. Currency valuations for payment liability will be based on exchange rates published on the date the Vision Services were rendered.
Section 5: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps.

What to Do if You Have a Question
You can contact Customer Service at 1-800-638-3120 if you have any questions. Our Customer Service representatives are able to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint
You can contact Customer Service at 1-800-638-3120 if you have a complaint. Our Customer Service representatives are able to take your call during regular business hours, Monday through Friday.

You can also send your complaint to us in writing. The Customer Service representative can provide you with the appropriate address.

If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

How to Appeal a Claim Decision

How to Request an Appeal
If you disagree with either a claim determination or a rescission of coverage determination, you can contact us in writing to request an appeal.

Your request for an appeal should include:

- The patient's name and Policy number.
- The date(s) of Vision 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 appeal request must be submitted to us within 180 days after you receive the claim denial.

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 Vision Provider with appropriate expertise in the field. This Vision Provider will be one who was not involved in the prior determination. We may consult with, or seek the participation of, vision experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent vision claim information. You have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. This information is available at your request and is free of charge. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge.

**Appeals Determinations**

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

For appeals of claims as identified above, the appeal will be conducted and you will be notified of the decision within 60 days from receipt of a request for appeal of a denied claim.

Please note that we base our decision only on whether or not benefits are available under the Policy for the proposed treatment or procedure. We don't determine whether the pending Vision Service is necessary or appropriate. That decision is between you and your Vision Provider.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in to you.
Section 6: General Legal Provisions

Entire Policy
The Policy issued to the Enrolling Group, includes the following:

1. Certificate(s),
2. Schedule(s) of Covered Vision Services,
3. The Enrolling Group’s application, and
4. Any Amendments or Riders.

These forms constitute the entire Policy. All statements made by the Enrolling Group or by a Subscriber will, in the absence of fraud, be deemed representations and not warranties.

Time Limit on Certain Defenses
The validity of the contract shall not be contested, except for non-payment of premiums, after it has been in force for two (2) years from the date of issue.

No statement made for the purpose of effecting insurance coverage under the contract with respect to a person shall be used to:

! void the insurance with respect to which such statement was made, or
! reduce benefits after the insurance has been in force for a period of two (2) years.

That is, unless the statement is contained in a written document signed by the person making that statement and they have received a copy of that document.

Amendments and Alterations
Amendments to the Policy are effective upon 31 days written notice to the Enrolling Group. Riders are effective on the date specified by the Company. No change will be made to the Policy unless an Amendment or a Rider that is signed by an officer of the Company makes it. No agent has authority to change the Policy or to waive any of its provisions.

Relationship Between Parties
The relationships between us and Network Vision Providers and relationships between us and Enrolling Groups are solely contractual relationships between independent contractors. Network Vision Providers and Enrolling Groups are not agents or employees of the Company. The Company, or any employees of the Company, are not agents or employees of Network Vision Providers or Enrolling Groups.
The relationship between a Network Vision Provider and any Covered Person is that of Vision Provider and patient. The Network Vision Provider is solely responsible for the services provided to any Covered Person. The Enrolling Group is solely responsible for enrollment and Coverage classification changes (including termination of a Covered Person’s Coverage through the Company) and for the timely payment of the Policy Charge.

**Information and Records**

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

By accepting Coverage under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We 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 Subscriber’s enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any records concerning vision care services, which are necessary:

- To implement and administer the terms of the Policy;
- For appropriate review or quality assessment; or
- As required by us under law or regulation.

During and after the term of the Policy, our related entities and we may use and transfer the information gathered under the Policy. Information transferred must be in a de-identified format for commercial purposes. This includes research and analytic purposes.

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

If you request vision 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 will designate other persons or entities to:

1. request records or information from or related to you, and
2. to release those records as necessary.

Our designees have the same rights to this information as we have.
ERISA
When the Policy is purchased by the Enrolling Group to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the welfare plan, as those terms are used in ERISA.

Examination of Covered Persons
If there is a question or dispute concerning Coverage for Vision Services, we may reasonably require that a Network Vision Provider examine you. The Vision Provider must be acceptable to us. This examination will be done at our expense.

Clerical Error
If a clerical error or other mistake occurs, that error will not deprive you of Coverage under the Policy. It does not create a right to benefits or Coverage.

Notice
When we provide written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to you.

Workers' Compensation Not Affected
The Coverage provided under the Policy does not:

! Substitute for any requirements for coverage by workers' compensation insurance.

! Affect any requirements for coverage by workers' compensation insurance.

Conformity with Statutes
Any provision of the Policy which, on its effective date, is in conflict with the requirements of applicable state or federal statutes or regulations is hereby amended to conform to the minimum requirements of such statutes and regulations.

Waiver/Estoppel
Nothing in the Policy, Certificate or Schedule of Covered Vision Services is considered to be waived by any party unless the party claiming the waiver receives the waiver in writing. A waiver of one provision does not constitute a waiver of any other. A failure of either party to enforce at any time any of the provisions of the Policy, Certificate or Schedule of Covered Vision Services, or to exercise any option which is herein provided, shall in no way be construed to be a waiver of such provision of the:

! Policy,
Certificate, or
Schedule of Covered Vision Services.

**Headings**

The following items do not affect the meaning or interpretation of the Policy, **Certificate** or **Schedule of Covered Vision Services**:

- headings,
- titles, and
- any table of contents contained in the Policy.

They are for reference purposes only. They do not, in any way, affect the meaning or interpretation of the Policy, **Certificate** or **Schedule of Covered Vision Services**.

**Unenforceable Provisions**

If any provision of the Policy, **Certificate** or **Schedule of Covered Vision Services** is held to be illegal or unenforceable by a court of competent jurisdiction, the remaining provisions will remain in effect. Any illegal or unenforceable provision will be modified so as to conform to the original intent of the:

- Policy,
- **Certificate**, or
- **Schedule of Covered Vision Services**,

to the greatest extent legally permissible.

**Subrogation and Reimbursement**

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the Coverage provided by this **Certificate**, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for:

- uninsured or uninsured motorist protection,
- no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise),
- workers' compensation coverage, or other insurance carriers or third party administrators.

Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including:

- Providing any relevant information requested by us.
- Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
- Responding to requests for information about any accident or injuries.
- Making court appearances.
- Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.

That failure to cooperate in this manner shall be deemed a breach of contract. This may result in the termination of vision benefits or the instigation of legal action against you.

That we have the authority to resolve all disputes regarding the interpretation of the language stated herein.

That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.

That regardless of whether you have been fully compensated or made whole, we may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain. This is whether in the form of a settlement (either before or after any determination of liability), or judgment. Such proceeds available for collection are to include any and all amounts earmarked as non-economic damage settlement or judgment.
That benefits paid by us may also be considered to be benefits advanced.

That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.

That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone. Failure to hold funds as such will be deemed as a breach of contract. This may result in the termination of vision benefits or the instigation of legal action against you.

That we may set off from any future benefits otherwise provided by us the value of benefits paid or advanced under this section to the extent not recovered by us.

That you will not accept any settlement that does not fully compensate or reimburse us without our written approval, nor will you do anything to prejudice our rights under this provision.

That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and benefits we provided, plus reasonable costs of collection.

That our rights will be considered as the first priority claim against Third Parties, to be paid before any other of your claims are paid. Third Parties include tortfeasors from whom you are seeking recovery.

That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.

That we shall not be obligated in any way to pursue this right independently or on your behalf.

That in the case of your wrongful death, the provisions of this section will apply to:

- your estate,
- the personal representative of your estate, and
- your heirs or beneficiaries.

That the provisions of this section apply to:

- the parents,
- guardian, or
- other representative of a Dependent child
who incurs a sickness or injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor’s Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

**Refund of Overpayments**

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

- All or some of the expenses were not paid by you or did not legally have to be paid by you.
- All or some of the payment we made exceeded the benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, then you agree to help us get the refund when requested.

If you, 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 for you that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

**Limitation of Action**

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process. This process is described in *Section 5: Questions, Complaints and Appeals*. If you want to bring a legal action against us after completing that process, you must do so within three years of the date we notified you of our final decision on your appeal. If you do not do so, you lose any rights to bring such an action against us.
Section 7: Rhode Island Continuation of Coverage

Qualifying Events for Continuation Coverage under State Law
Coverage must have ended due to termination of the Subscriber from employment with the Enrolling Group because of one of the following qualifying events:

- Involuntary layoff.
- Death.
- The workplace ceases to exist.
- The permanent reduction in the size of the workforce.

Election Period for Continuation Coverage under State Law
You must elect continuation coverage within 30 days of receiving this notification. You should obtain and election form from the Participating Employer.

You should forward all monthly Premiums to the Participating Employer for payment to us.

If the workplace ceases to exist, you should forward all monthly Premiums directly to us.

Terminating Events for Continuation Coverage under State Law
Continuation coverage under the Policy will end on the earliest of the following dates:

- 18 months from the date your continuation began.
- The date coverage ends for failure to make timely payment of the Premiums.
- The date coverage is or could be obtained under any other group health plan.
- The last day of time period equal to the length of your continuous employment with the Participating Employer.

Continuation Coverage under State Law for After Judgment Absolute of Divorce or of Separate Support
Continuation coverage under state law is provided to the spouse of a Subscriber in the event of a judgment for divorce if the order for continuation coverage is included in the judgment.

Continuation coverage under the Policy will end on the earliest of the following dates:

- The date coverage ends for the Subscriber.
- The date of the remarriage of either the Subscriber or the spouse.
The date as provided in the judgment.
Section 8: Covered Vision Services

Routine Vision Examination
A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which the Covered Person resides including:

A. A case history, including chief complaint and/or reason for examination, patient medical/eye history, current medications, etc.;

B. Recording of monocular and binocular visual acuity, far and near, with and without present correction (20/20, 20/40, etc.);

C. Cover test at 20 feet and 16 inches (checks eye alignment);

D. Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception;

E. Pupil responses (neurological integrity);

F. External exam;

G. Refraction (when applicable) - to determine power of corrective lenses for distance and near vision;

H. Phorometry/Binocular testing - far and near: how well eyes work as a team;

I. Tonometry, when indicated: test pressure in eye (glaucoma check);

J. Ophthalmoscopic examination of the internal eye;

K. Confrontation visual fields;

L. Biomicroscopy;

M. Color vision testing;

N. Diagnosis/prognosis;

O. Dilation (when indicated) - Examine the internal structures of the eye; and

P. Specific recommendations.

Or in lieu of a routine exam, Refraction to determine power of corrective lenses for distance and near vision.

Post examination procedures will be performed only when materials are required.
Retinal Imaging
Film or digital pictures taken of the back of your eye, which includes the retina and optic nerve.

Eyeglass Lenses
Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

Eyeglass Frames
A structure that contains eyeglasses lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

Optional Lens Extras
Special lens stock or modifications to lenses that do not correct visual acuity problems. Optional Lens Extras include options such as, but not limited to, tinted lenses, polycarbonate lenses, high-index lenses, progressive lenses, ultraviolet coating, scratch-resistant coating, edge coating, and photochromic coating.

Contact Lenses
Lenses worn on the surface of the eye to correct visual acuity limitations.

Necessary Contact Lenses
This benefit is available where a Vision Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Provider and not by us.

Contact lenses are necessary if the Covered Person has:
A. Keratoconus;
B. Anisometropia;
C. Irregular corneal/astigmatism;
D. Aphakia;
E. Facial deformity; or
F. Corneal deformity.

Contact Lens Fitting & Evaluation
A contact lens evaluation and fitting includes examination and measurement of the eyes and adjacent structures to determine the contact lens size, design and power to achieve and maintain eye health, comfort and vision.
Section 9: General Exclusions

The following Services and materials are excluded from Coverage under the Policy:

A. Non-prescription items (e.g. Plano lenses) other than those listed in the Schedule(s) of Covered Vision Services.

B. Services that the Covered Person, without cost, obtains from any governmental organization or program.

C. Services for which the Covered Person may be compensated under Workers’ Compensation Law, or other similar employer liability law.

D. Any eye examination required by an employer as a condition of employment, by virtue of a labor agreement, a government body, or agency.

E. Medical or surgical treatment for eye disease, which requires the services of a Physician.

F. Replacement or repair of lenses and/or frames that have been lost or broken.

G. Optional Lens Extras not listed in the Schedule(s) of Covered Vision Services.

H. Missed appointment charges.

I. Applicable sales tax charged on Services.

J. Services that are not specifically covered by the Policy.

K. Procedures that are considered to be Experimental, Investigational or Unproven. 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 Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

L. Any Vision Service rendered by the Policyholder.

M. Intraocular lenses.
# Schedule of Covered Vision Services

The following Vision Services will be covered, subject to a Copayment, when obtained from Network Providers.

When obtaining these Vision Services from a Network Provider, you will be required to pay a Copayment at the time of service for certain Vision Services. The amount of Copayment that a Network Provider will charge is as noted in the column "Network Benefit" in the chart below.

When obtaining these Vision Services from a non-Network Provider, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement for non-Network Providers will be limited to the amounts noted in the column "Non-Network Benefit" in the chart below.

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>FREQUENCY OF SERVICE</th>
<th>NETWORK BENEFIT</th>
<th>NON-NETWORK BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Vision Examination</td>
<td>Once every 12 months</td>
<td>After a Copayment of $10.00</td>
<td>To a maximum of a $40.00 allowance</td>
</tr>
<tr>
<td>Refraction Only in Lieu of Routine Vision Examination</td>
<td>Once every 12 months</td>
<td>$0 allowance</td>
<td>To a maximum of a $40.00 allowance</td>
</tr>
<tr>
<td>Retinal Imaging</td>
<td>Once every 12 months</td>
<td>After a Copayment of $39.00</td>
<td></td>
</tr>
<tr>
<td>Contact Lens Fitting and Evaluation</td>
<td>Once every 12 months</td>
<td>To a maximum of a $60.00 allowance</td>
<td></td>
</tr>
<tr>
<td>Eyeglass Frames&lt;sup&gt;A&lt;/sup&gt;</td>
<td>Once every 24 months</td>
<td>After a Copayment of $25.00&lt;sup&gt;B&lt;/sup&gt; To a maximum of a $175.00 allowance</td>
<td>To a maximum of a $45.00 allowance</td>
</tr>
<tr>
<td>Eyeglass Lenses&lt;sup&gt;A&lt;/sup&gt;</td>
<td>Once every 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision&lt;sup&gt;*&lt;/sup&gt;</td>
<td>After a Copayment of $25.00&lt;sup&gt;B&lt;/sup&gt;</td>
<td>To a maximum of a $40.00 allowance</td>
<td></td>
</tr>
<tr>
<td>Bifocal-lined</td>
<td>After a Copayment of $25.00&lt;sup&gt;B&lt;/sup&gt;</td>
<td>To a maximum of a $60.00 allowance</td>
<td></td>
</tr>
<tr>
<td>Trifocal-Lined</td>
<td>After a Copayment of</td>
<td>To a maximum of a</td>
<td></td>
</tr>
<tr>
<td>SERVICE</td>
<td>FREQUENCY OF SERVICE</td>
<td>NETWORK BENEFIT</td>
<td>NON-NETWORK BENEFIT</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>----------------------</td>
<td>-----------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Lenticular</td>
<td></td>
<td>$25.00^B</td>
<td>$80.00 allowance</td>
</tr>
<tr>
<td>Optional Lens Extras</td>
<td>Once every 12 months</td>
<td>After a Copayment of $25.00^B</td>
<td>To a maximum of a $80.00 allowance</td>
</tr>
<tr>
<td>Polycarbonate for Dependent children up to age 19</td>
<td></td>
<td>After a Copayment of $0.00</td>
<td></td>
</tr>
<tr>
<td>Contact Lenses^A</td>
<td>Once every 12 months</td>
<td>To a maximum of a $175.00 allowance</td>
<td>To a maximum of a $150.00 allowance</td>
</tr>
<tr>
<td>Necessary Contact Lenses^A</td>
<td>Once every 12 months</td>
<td>After a Copayment of $25.00</td>
<td>To a maximum of a $210.00 allowance</td>
</tr>
</tbody>
</table>

Optional Lens Extras:

! Eyeglass Lenses: The following Optional Lens Extras are covered in full:
  - Scratch-resistant Coating

^A You are eligible to select only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Lenses and Eyeglass Frames) or Contact Lenses. If you select more than one of these Vision Services, only one Service will be covered. Once the contact lens option is selected and the lenses are fitted, they may not be exchanged for eyeglasses.

^B If you purchase Eyeglass Lenses and Eyeglass Frames at the same time from the same Network Provider, only one Copayment will apply to those Eyeglass Lenses and Eyeglass Frames together.

*Single vision lens are defined as one single power across their entire surface with a single optical center and are made from CR-39 or glass material.
Telehealth Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified to provide Coverage for Telehealth Vision Services.

*The following definitions are added to the Certificate under Section 1: Definitions:*

**Distant Site** - the site the Vision Provider is located while providing Vision Services by means of Telehealth.

**Originating Site** - the site which a Covered Person is located at the time Vision Services are provided to them by means of Telehealth. This may be a Covered Person's home where appropriate. We and the Vision Provider may agree to alternative siting arrangements deemed appropriate by the parties.

**Store and Forward Technology** - the technology used to enable the transmission of a Covered Person's vision information from an Originating Site to the Vision Provider at the Distant Site without the Covered Person being present.

**Telehealth** - the delivery of Vision Services by means of real time two-way electronic audiovisual communications including the application of secure video conferencing or Store-and-Forward Technology to provide or support Vision Services delivery, which facilitate the assessment, diagnosis, treatment and care management of a Covered Person's Vision care while the Covered Person is at an Originating Site and the Vision Provider is at the Distant site. Telehealth does not include an audio-only telephone conversation, email message or facsimile transmission between the Vision Provider and Covered Person. Telehealth does not include an automated computer program used to diagnose and/or treat ocular or refractive conditions.

*The following provision is added to the Certificate, Section 8: Covered Vision Services:*

**Telehealth Services**

Coverage is provided for Vision Services received through Telehealth. Coverage for Vision Services provided through Telehealth shall be equivalent to the Coverage for the same Services provided via face-to-face contact between a Vision Provider and a Covered Person. Covered Services are subject to any applicable Deductible, Copayment, or Coinsurance.

We will not exclude a Vision Service for Coverage solely because such Vision Service is provided only through Telehealth and not through in-person consultation between the Covered Person and a Vision Provider, provided Telehealth is appropriate for the provisions of such Vision Services.

This amendment is subject to applicable terms and conditions of the Policy. All other provisions of the Policy remain unchanged.
Language Assistance Services

We provide free language services to help you communicate with us. We offer
interpreters, letters in other languages, and letters in other formats like large print. To
get help, please call 1-800-638-3120, or the toll-free member phone number listed on
your vision plan ID card TTY 711. We are available Monday through Friday, 8 a.m. to 8
p.m. ET.
ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-800-638-3120.

XIN LƯU Y: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-800-638-3120.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-638-3120 번으로 전화해 주시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-800-638-3120.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является Русский (Russian). Позвоните по номеру 1-800-638-3120.

اتبعت: إذا كنت تتحدث العربية (Arabic) تتبي: إن خدمات المساعدة اللغوية المجانية مثالية لك. الرجاء الأتصال بـ 1-800-638-3120.

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisyè sévis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-800-638-3120.

ATTENTION : Si vous parlez français (French), des services d’aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-800-638-3120.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-800-638-3120.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue para 1-800-638-3120.

ATTENZIONE: In caso la lingua parlata sia l’italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-800-638-3120.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfeleistungen zur Verfügung. Rufen Sie 1-800-638-3120 an.

注意事項：日本語 (Japanese) を話される場合、無料の言語支援サービスをご利用いただけます。1-800-638-3120 にお電話ください。

توضيح: إذا كنت تتحدث الفارسية (Farsi) تجب: خدمات إعداد للطلاب باللغة الإنجليزية متوفرة. توجه: 1-800-638-3120.

कृपया ध्यान दें, वदि आप हिंदी (Hindi) भाषी हैं तो आपके लिए भाषा सहायता सेवाएं निष्ठुल उपलब्ध हैं। कृपया पर कल करें 1-800-638-3120.
CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-800-638-3120.

Pakdaaar: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-800-638-3120.

Dîl Baa’âkonînîzin: Dinî (Navajo) bizaad bee yânîl’t’go, saad bee âka’anida’awol’gii, t’âa jîlik’eh, bee na’aâhôô’t’. T’aa shoodi kohji’ 1-800-638-3120 hodîlinih.

Ogow: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-800-638-3120.

Pròsòkhi: Aan mîlîte Ellînîkà (Greek), upàrchei dwreewn bohëciei stëg glëssä sâç. Pàrakalëisëte na kaleste 1-800-638-3120.

Gujarati: Lînê (Hindi) gujaratî (Gujarati) bhojna li te aapna bhaavâhî matraam, khela

Tûla li 1-800-638-3120 bar dîlêh li. TTY 711
Notice of Non-Discrimination

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, Utah 84130
UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call 1-800-638-3120 or the toll-free member phone number listed on your vision plan ID card, TTY 711. We are available Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf


Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)


For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "we" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.
Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

How to Request an Appeal

If you disagree with a claim determination or a rescission of coverage determination, you can contact us in writing to request an appeal.

Your request for an appeal should include:

- The patient's name and Policy number.
- The date(s) of Vision 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 appeal request must be submitted to us within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a Vision care professional with experience in the field, who was not involved in the prior determination. We may consult with, or ask vision experts to take part in the appeal process. You consent to this referral and the sharing of needed vision 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 related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

You will be provided written or electronic notification of the decision on your appeal as follows:
For appeals of Benefits, the appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for Benefits.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

You may have the right to external review through an Independent Review Organization (IRO) upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.
VISION PLAN NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

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.

Effective January 1, 2019

We are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health care condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular vision plan, we will post the revised notice on your vision plan website, such as www.myuhcvision.com. We have the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural safeguards in the handling and maintenance of our enrollee information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Use or Disclose Information

We must use and disclose your health information to provide that information:

! To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice.

! To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.
**We have the right to** use and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.

- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.

- **For Health Care Operations.** We may use or disclose health information as needed to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.

- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.

- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.

- **For Underwriting Purposes.** We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.

- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

**We may** use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
To Persons Involved With Your Care. We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.

For Public Health Activities such as reporting or preventing disease outbreaks to a public health authority.

For Reporting Victims of Abuse, Neglect or Domestic Violence to government authorities that are authorized by law to receive such information, including a social service or protective service agency.

For Health Oversight Activities to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.

For Judicial or Administrative Proceedings such as in response to a court order, search warrant or subpoena.

For Law Enforcement Purposes. We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

To Avoid a Serious Threat to Health or Safety to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.

For Specialized Government Functions such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.

For Workers' Compensation as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.

For Research Purposes such as research related to the review of certain treatments or the prevention of disease or disability, if the research study meets privacy law requirements.

To Provide Information Regarding Decedents. We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as needed to carry out their duties.
! **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.

! **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if needed (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

! **To Business Associates** that perform functions on our behalf or provide us with services if the information is needed for such functions or services. Our business associates are required, under contract with us and according to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as shown in our contract as permitted by federal law.

! **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:

1. Alcohol and Substance Abuse
2. Biometric Information
3. Child or Adult Abuse or Neglect, including Sexual Assault
4. Communicable Diseases
5. Genetic Information
6. HIV/AIDS
7. Mental Health
8. Minors' Information
9. Prescriptions
10. Reproductive Health
11. Sexually Transmitted Diseases

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as stated in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written
authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, call the phone number listed on your vision plan ID card.

What Are Your Rights
The following are your rights with respect to your health information:

You have the right to ask to restrict uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.

You have the right to ask to receive confidential communications of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you confirm your request in writing. In addition, any requests to change or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.

You have the right to see and get a copy of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.

You have the right to ask to amend certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
You have the right to receive an accounting of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or according to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.

You have the right to a paper copy of this notice. You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may get a copy of this notice on your vision plan website, such as www.myuhcvision.com.

Exercising Your Rights

Contacting your Vision Plan. If you have any questions about this notice or want information about exercising your rights, please call the toll-free member phone number on your vision ID card or you may call us at 1-800-638-3120, or TTY 711.

Submitting a Written Request. You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record, to us at the following address:

UnitedHealthcare
Vision HIPAA - Privacy Unit
PO Box 30978
Salt Lake City, UT 84130

Filing a Complaint. If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

2 This Vision Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: UnitedHealthcare Insurance Company and UnitedHealthcare Insurance Company of New York. This list of vision plans is complete as of the effective date of this notice. For a current list of vision plans subject to this notice go to www.uhc.com/privacy/entities-fn-v3-en or call 1-800-638-3120.
FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2019

We are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number.
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history.
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors.
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations.
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer
safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on your vision plan ID card or call us at 1-800-638-3120, or TTY 711.

3 For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, beginning on the first page of the Vision Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliate: Spectera, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to any other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products. For a current list of vision plans subject to this notice go to www.uhc.com/privacy/entities-fn-v3-en or call 1-800-638-3120.

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

Receive Information about Your Plan and Benefits
You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if applicable, filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

You are entitled to get, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if applicable and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage
You are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan due to a qualifying event. You or your Dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation rights. Review the Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to get copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not
receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also get certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.
ERISA Statement
If the Group is subject to ERISA, the following information applies to you.

Summary Plan Description
Name of Plan: Children's Friend Welfare Benefit Plan

Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:

Children's Friend
153 Summer St
Providence, RI 02903
(401) 276-4303

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan, except to the extent the Plan Sponsor has assigned or allocated to other persons or entities one or more fiduciary responsibilities with respect to the Plan.

Claims Fiduciary: UnitedHealthcare Insurance Company ("UnitedHealthcare,“ refer to your Certificate of Coverage for details on the legal entity that provides your coverage) is your Plan's Claims Fiduciary and has been assigned this responsibility by your Plan Sponsor. Your Claims Fiduciary has the authority to require eligible individuals to furnish it with information necessary for the proper administration of your Plan.

Employer Identification Number (EIN): 05-0258819

Plan Number: 501

Plan Year: January 1 through December 31

Type of Plan: Health care coverage plan

Name, Business Address, and Business Telephone Number of Plan Administrator:

Children's Friend
153 Summer St
Providence, RI 02903
(401) 276-4303

Type of Administration of the Plan: Your Plan is fully insured. Benefits are provided under a group insurance contract entered into between your Plan Sponsor and UnitedHealthcare. Claims for benefits are sent to UnitedHealthcare. Your employer and UnitedHealthcare share responsibility for administering the plan.

UnitedHealthcare
185 Asylum Street
Hartford, CT 06103-0450
860-702-5000

Person designated as Agent for Service of Legal Process: Plan Administrator
Discretionary Authority of Plan Administrator and Other Plan Fiduciaries: The Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for benefits in accordance with the terms of the Plan. Any interpretation or determination made according to such discretionary authority shall be given deference and be legally binding on all parties and subject to review by a legal authority only to the extent the decision was arbitrary and capricious.

Source of Contributions and Funding under the Plan: There are no contributions to the Plan. Any required employee contributions are used to partially reimburse the Plan Sponsor for Premiums under the Plan. Benefits under the Plan are funded by the payment of Premium required by the group Policy.

Method of Calculating the Amount of Contribution: Employee-required contributions to the Plan Sponsor are the employee’s share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

Qualified Medical Child Support Orders: The Plan’s procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

Amendment or Termination of the Plan: Your employer, as the Plan Sponsor, has the right to amend or terminate this Plan at any time. Note that the insurance contract, which is how benefits under the Plan are provided, is not necessarily the same as the Plan. As a result, termination of the insurance contract does not necessarily terminate the Plan.
SUMMARY PLAN DESCRIPTION

Children's Friend
ASO Navigate GIL Mod

Effective: January 1, 2021
Group Number: 753421
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SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance-Related and Addictive Disorder Administrator: 1-800-377-5154.
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 30555, Salt Lake City, UT 84130-0555.

Children's Friend is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members under the Children's Friend Welfare Benefit Plan. It includes summaries of:

- Who is eligible.
- Services that are covered, called Covered Health Services.
- Services that are not covered, called Exclusions and Limitations.
- How Benefits are paid.
- Your rights and responsibilities under the Plan.

This SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic SPD for this Plan.

IMPORTANT

The healthcare service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 14, Glossary.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Plan.

Children's Friend intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice subject to any collective bargaining agreements between the Employer and various unions, if applicable. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

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

Please read this SPD thoroughly to learn how the Children’s Friend Welfare Benefit Plan works. If you have questions contact your local Human Resources department or call the number on your ID card.
How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments or request printed copies by contacting Human Resources.
- Capitalized words in the SPD have special meanings and are defined in Section 14, Glossary.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, Glossary.
- Children's Friend is also referred to as Company.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.
SECTION 2 - INTRODUCTION

What this section includes:
- Who's eligible for coverage under the Plan.
- The factors that impact your cost for coverage.
- Instructions and timeframes for enrolling yourself and your eligible Dependents.
- When coverage begins.
- When you can make coverage changes under the Plan.

Eligibility
You are eligible to enroll in the Plan if you are a regular full-time employee who is scheduled to work at least 30 hours per week.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- Your Spouse, as defined in Section 14, Glossary.
- Your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian.
- An unmarried child age 26 or over who is or becomes disabled and dependent upon you.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse are both covered under the Children's Friend Welfare Benefit Plan, you may each be enrolled as a Participant or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Children's Friend Welfare Benefit Plan, only one parent may enroll your child as a Dependent.

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, as described in Section 13, Other Important Information.

Cost of Coverage
You and Children's Friend share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.
Note: The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of Children's Friend's cost in covering a Domestic Partner may be imputed to the Participant as income. In addition, the share of the Participant's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions.

Your contributions are subject to review and Children's Friend reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling Human Resources.

How to Enroll
To enroll, call Human Resources within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following January 1.

Important
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact Human Resources within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins
Once Human Resources receives your properly completed enrollment, coverage will begin on the first day of the month following your date of hire. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the date of your marriage, provided you notify Human Resources within 31 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement is effective the date of the family status change, provided you notify Human Resources within 31 days of the birth, adoption, or placement.

If You Are Hospitalized When Your Coverage Begins
If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan. These Benefits are subject to any prior carrier’s obligations under state law or contract.

You should notify UnitedHealthcare of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. For Benefit plans that have a Network
Benefit level, Network Benefits are available only if you receive Covered Health Services from Network providers.

**Changing Your Coverage**

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- Your marriage, divorce, legal separation or annulment.
- Registering a Domestic Partner.
- The birth, legal adoption, placement for adoption or legal guardianship of a child.
- A change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan.
- Loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis.
- Your death or the death of a Dependent.
- Your Dependent child no longer qualifying as an eligible Dependent.
- A change in your or your Spouse's position or work schedule that impacts eligibility for health coverage.
- Contributions were no longer paid by the employer (this is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer).
- You or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent.
- Benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent.
- Termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact Human Resources within 60 days of termination).
- You or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact Human Resources within 60 days of the date of determination of subsidy eligibility).
- You or your Dependent lose eligibility for coverage in the individual market, including coverage purchased through a public exchange or other public market established under the Affordable Care Act (Marketplace) (other than loss of eligibility for coverage due to failure to pay premiums on a timely basis or termination of coverage for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact) regardless of whether you or your Dependent may enroll in other individual market coverage, through or outside of a Marketplace.
CHILDREN’S FRIEND MEDICAL ASO NAVIGATE GIL MOD

- A strike or lockout involving you or your Spouse.
- A court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact Human Resources within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

**Note:** Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

**Change in Family Status - Example**

Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in Children’s Friend’s medical plan, because her husband, Tom, has family coverage under his employer’s medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under Children’s Friend’s medical plan outside of annual Open Enrollment.
SECTION 3 - HOW THE PLAN WORKS

What this section includes:
■ Selecting a Primary Physician.
■ Accessing Benefits.
■ Eligible Expenses.
■ Copayment.
■ Coinsurance.
■ Out-of-Pocket Maximum.

Selecting a Network Primary Physician
As a participant in this Plan, you must select a Network Primary Physician, who is located in the geographic area of the permanent residence of the Participants, in order to obtain Benefits. In general health care terminology, a Primary Physician may also be referred to as a Primary Care Physician or PCP. A Network Primary Physician will be able to coordinate all Covered Health Services and submit electronic referrals online to UnitedHealthcare for services from Network Physicians. If you are the custodial parent of an enrolled Dependent child, you must select a Network Primary Physician, who is located in the geographic area of the permanent residence of the Participants, for that child. If you do not select a Network Primary Physician for yourself or your enrolled Dependent child, one will be assigned.

You may select any Network Primary Physician who is located in the geographic area of the permanent residence of the Participants and is accepting new patients. You may designate a Network Physician who specializes in pediatrics (including pediatric subspecialties, based on the scope of that provider’s license under applicable state law) as the Network Primary Physician for an enrolled Dependent child. For obstetrical or gynecological care, you do not need a referral from a Network Primary Physician and may seek care directly from any Network Physician who specializes in obstetrics or gynecology.

You can obtain a list of Network Primary Physicians and/or Network obstetricians and gynecologist by contacting UnitedHealthcare at the number on your ID card or logging onto www.myuhc.com.

You may change your Network Primary Physician by calling the telephone number shown on your ID card or by logging onto www.myuhc.com. Changes are permitted once per month. Changes submitted on or before the 15th of the month will be effective on the first day of the following month. Changes submitted on or after the 16th of the month will be effective on the first day of the second following month.

Covered Health Services must be provided by or referred by your Primary Physician. If care from another Network Physician is needed, your Primary Physician will provide you with a referral. The referral must be received before the services are rendered.
IMPORTANT
If you see a Network Physician without a referral from your Primary Physician, Benefits will not be paid. You do not need a referral to see an obstetrician/gynecologist or to receive services through the Mental Health/Substance-Related and Addictive Disorders Services Administrator.

Accessing Benefits
UnitedHealthcare Navigate offers a limited Network of providers. To obtain Benefits, you must receive Covered Health Services from a UnitedHealthcare Navigate Network provider. You can confirm that your provider is a UnitedHealthcare Navigate Network provider by calling the telephone number on your ID card or you can access a directory of providers online at www.myuhc.com.

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this SPD, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

You should confirm that your provider is a UnitedHealthcare Designated Network Benefits or Navigate Network provider, including when receiving Covered Health Services for which you received a referral from your Primary Physician.

Designated Network Benefits apply to Covered Health Services that are provided by a Network Physician or other provider that is identified as a Designated Provider. Only certain Physicians and providers have been identified as a Designated Provider. Designated Network Benefits are available only for specific Covered Health Services as identified in Section 5, Plan Highlights.

When Designated Network Benefits apply, they are included in and subject to the same Annual Deductible and Out-of-Pocket Maximum requirements as all other Covered Health Services provided by Network providers.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Benefits for facility services apply when Covered Health Services are provided at a Network facility. Benefits include Physician services provided in a Network facility by a Network or a non-Network radiologist, anesthesiologist, pathologist, Emergency room Physician and consulting Physician. Benefits also include Emergency Health Services.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare’s Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program in Section 14, Glossary, of the SPD for details about how the Shared Savings Program applies.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way
of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

**Network Providers**

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

Network providers are independent practitioners and are not employees of Children's Friend or UnitedHealthcare. It is your responsibility to select your provider.

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

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 UnitedHealthcare. A directory of providers is available online at www.myuhc.com or by calling the number on your ID card to request a copy.

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 Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact the number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of UnitedHealthcare’s products. Refer to your provider directory or contact UnitedHealthcare for assistance.

**Health Services from Non-Network Providers**

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from a non-Network provider. In this situation, your Network Physician will notify the Claims Administrator, and if the Claims Administrator confirms that care is not available from a Network provider, the Claims Administrator will work with you and your Network Physician to coordinate care through a non-Network provider.
When you receive Covered Health Services through a Network Physician, the Plan will pay Network Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a non-Network provider.

### Possible Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to provide and coordinate all of your future Covered Health Services.

If you don’t make a selection within 31 days of the date you are notified, UnitedHealthcare will select a single Network Physician for you.

In the event that you do not use the selected Network Physician, Benefits will not be paid.

### Designated Providers

If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Provider chosen by UnitedHealthcare. If you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Provider, UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare’s discretion.

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

You or your Network Physician must notify UnitedHealthcare of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify UnitedHealthcare in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Provider) or other non-Network provider, Benefits will not be paid.

### Additional Network Availability

Certain Covered Health Services defined below may also be provided through the W500 Network. Go to [www.myuhc.com](http://www.myuhc.com) or contact UnitedHealthcare for the W500 provider directory. You are eligible for Benefits when these certain Covered Health Services are received from providers who are contracted with UnitedHealthcare through the W500 Network.
These Covered Health Services are limited to the services listed below, as described in Section 6, Additional Coverage Details:

- Emergency Health Services - Outpatient.
- Hospital - Inpatient Stay, when you are admitted to the Hospital on an unscheduled basis because of an Emergency. Benefits for services provided while you are confined in a Hospital also include Covered Health Services as described under Physician Fees for Surgical and Medical Services.
- Urgent care services provided as described under Urgent Care Center Services. Urgent care services are those 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.

Also, if UnitedHealthcare determines that specific Covered Health Services are not available from a Navigate Network provider, you may be eligible for Benefits when Covered Health Services are received from a W500 Network provider. In this situation, before you receive these Covered Health Services, your Navigate Network Physician will notify UnitedHealthcare and, if UnitedHealthcare confirms that the Covered Health Services are not available from a Navigate Network provider, UnitedHealthcare will work with you and your Navigate Network Physician to coordinate these Covered Health Services through a W500 Network provider.

Eligible Expenses

Children’s Friend has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

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

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

- When Covered Health Services are received from a Designated Network Benefits and Network provider, Eligible Expenses are UnitedHealthcare’s contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.
Don’t Forget Your ID Card

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

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is calculated as a flat dollar amount and is paid at the time of service or when billed by the provider. When Copayments apply, the amount is listed in Section 5, Plan Highlights, next to the description for each Covered Health Service.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

■ The applicable Copayment.
■ The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear in this section under the heading Eligible Expenses.

Copays count toward the Out-of-Pocket Maximum. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear in this section under the heading Eligible Expenses.

Out-of-Pocket Maximum

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

The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, as indicated in the table below, including Covered Health Services provided in Section 15, Outpatient Prescription Drugs. The Out-of-Pocket Maximum for Designated Network and Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drug products provided in Section 15, Outpatient Prescription Drugs.

The following table identifies what does and does not apply toward your Out-of-Pocket Maximum:
<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Applies to the Out-of-Pocket Maximum?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copays, even those for Covered Health Services available in Section 15, Outpatient Prescription Drugs.</td>
<td>Yes</td>
</tr>
<tr>
<td>Coinsurance Payments, even those for Covered Health Services available in Section 15, Outpatient Prescription Drugs.</td>
<td>Yes</td>
</tr>
<tr>
<td>Charges for non-Covered Health Services.</td>
<td>No</td>
</tr>
<tr>
<td>Ancillary or Therapeutically Equivalent Charges described in Section 15, Outpatient Prescription Drugs.</td>
<td>No</td>
</tr>
</tbody>
</table>
SECTION 4 - PERSONAL HEALTH SUPPORT AND PRIOR AUTHORIZATION

What this section includes:
- An overview of the Personal Health Support program.
- Covered Health Services which Require Prior Authorization.

Care Management

When you seek prior authorization as required, the Claims Administrator will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

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

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

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

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. When the Claims Administrator is called as required, they will work with you to implement the Personal Health Support process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. As of the publication of this SPD, the Personal Health Support program includes:

- **Admission counseling** - Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on your ID card for support.

- **Inpatient care management** - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician’s treatment plan is being carried out effectively.

- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment,
follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.

- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant’s specific chronic or complex condition.

- **Cancer Management** - You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path.

- **Kidney Management** - You have the opportunity to engage with a nurse that specializes in kidney disease, education and guidance with CKD stage 4/5 or ESRD throughout your care path.

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

### Prior Authorization

UnitedHealthcare requires prior authorization for certain Covered Health Services. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization.

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

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

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

Contacting UnitedHealthcare or Personal Health Support is easy. Simply call the number on your ID card.
Services for which you are required to obtain prior authorization are identified in Section 6, Additional Coverage Details within each Covered Health Service Benefit description. Please note that prior authorization timelines apply. Refer to the applicable Benefit description to determine how far in advance you must obtain prior authorization and any applicable reductions in Benefits.

**Please note that prior authorization is required even if you have a referral from your Primary Physician to seek care from another Network Physician.**

**Special Note Regarding Medicare**

If you are enrolled in Medicare on a primary basis (Medicare pays before the Plan pays Benefits) the prior authorization requirements do not apply to you. Since Medicare is the primary payer, the Plan will pay as secondary payer as described in Section 10, *Coordination of Benefits (COB)*. You are not required to obtain authorization before receiving Covered Health Services.
SECTION 5 - PLAN HIGHLIGHTS

What this section includes:
■ Payment Terms and Features.
■ Schedule of Benefits.

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

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Designated Network and Network Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Copays</strong></td>
<td></td>
</tr>
<tr>
<td>▪ Acupuncture.</td>
<td>$30</td>
</tr>
<tr>
<td>▪ Emergency Health Services.</td>
<td>$250</td>
</tr>
<tr>
<td>▪ Physician's Office Services - Primary Physician</td>
<td>Designated Network $0</td>
</tr>
<tr>
<td>▪ Physician's Office Services - Specialist.</td>
<td>Designated Network $0</td>
</tr>
<tr>
<td>▪ Physician's Office Services - Primary Physician</td>
<td>Network $30</td>
</tr>
<tr>
<td>▪ Physician's Office Services - Specialist.</td>
<td>Network $20</td>
</tr>
<tr>
<td>▪ Rehabilitation Services.</td>
<td>$20</td>
</tr>
<tr>
<td>▪ Urgent Care Center Services.</td>
<td>$50</td>
</tr>
</tbody>
</table>

Copays apply toward the Out-of-Pocket Maximum.
<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Designated Network and Network Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>No Annual Deductible.</td>
</tr>
<tr>
<td>■ Individual.</td>
<td></td>
</tr>
<tr>
<td>■ Family (not to exceed the applicable Individual amount for all Covered Persons in a family).</td>
<td></td>
</tr>
<tr>
<td><strong>Coupons:</strong> The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.</td>
<td>No Annual Deductible.</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td>$1,500</td>
</tr>
<tr>
<td>■ Individual.</td>
<td></td>
</tr>
<tr>
<td>■ Family (not to exceed the applicable Individual amount for all Covered Persons in a family).</td>
<td>$3,000</td>
</tr>
<tr>
<td>The Annual Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, <em>Outpatient Prescription Drugs</em>.</td>
<td></td>
</tr>
<tr>
<td><strong>Coupons:</strong> The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Out-of-Pocket Maximum.</td>
<td></td>
</tr>
<tr>
<td><strong>Lifetime Maximum Benefit</strong></td>
<td>Unlimited</td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Generally the following are considered to be essential benefits under the <em>Patient Protection and Affordable Care Act</em>:</td>
<td></td>
</tr>
<tr>
<td>Ambulatory patient services; emergency services, hospitalization; maternity and</td>
<td></td>
</tr>
<tr>
<td>Plan Features</td>
<td>Designated Network and Network Amounts</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>newborn care; mental health and substance-related and addictive disorders services (including behavioral health treatment); prescription drug products; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care).</td>
<td></td>
</tr>
</tbody>
</table>
## Schedule of Benefits

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acupuncture Services</strong></td>
<td>Designated Network and Network</td>
</tr>
<tr>
<td>See Section 6, <em>Additional Coverage Details</em>, for limits.</td>
<td>100% after you pay a Copayment of $30 per visit for services provided with a referral from your Primary Physician. No Benefits are payable for services provided without a referral from your Primary Physician.</td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
<td>Designated Network and Network</td>
</tr>
<tr>
<td>- Emergency Ambulance- Ground</td>
<td>100% after you pay a Copayment of $50 per transport</td>
</tr>
<tr>
<td>- Emergency Ambulance- Air</td>
<td>100% of eligible expenses</td>
</tr>
<tr>
<td>- Non-Emergency Ambulance-Ground</td>
<td>100% after you pay a Copayment of $50 per transport</td>
</tr>
<tr>
<td>- Non-Emergency Ambulance-Air</td>
<td>100% of eligible expenses</td>
</tr>
<tr>
<td>Ground or air ambulance, as the Claims Administrator determines appropriate.</td>
<td></td>
</tr>
<tr>
<td><strong>Cellular and Gene Therapy</strong></td>
<td>Designated Network and Network</td>
</tr>
<tr>
<td>Services must be received at a Designated Provider.</td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td><strong>Clinical Trials</strong></td>
<td>Designated Network and Network</td>
</tr>
<tr>
<td>Benefits are available when the Covered Health Services are provided by either Network or non-Network providers.</td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit</td>
</tr>
<tr>
<td>------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td><em>(The Amount Payable by the Plan based on Eligible Expenses)</em></td>
</tr>
<tr>
<td></td>
<td>Designated Network and Network</td>
</tr>
<tr>
<td>Congenital Heart Disease (CHD) Surgeries</td>
<td>100% for services provided with a referral from your Primary Physician</td>
</tr>
<tr>
<td>Dental Services - Accident Only</td>
<td>100%</td>
</tr>
<tr>
<td>Diabetes Services</td>
<td></td>
</tr>
<tr>
<td>Diabetes Self-Management and Training/</td>
<td>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td>Diabetic Eye Examinations/Foot Care</td>
<td></td>
</tr>
<tr>
<td>Diabetes Self-Management Items</td>
<td>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under <em>Durable Medical Equipment</em> in this section and in Section 15, <em>Outpatient Prescription Drugs</em>.</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>100%</td>
</tr>
<tr>
<td>See Section 6, <em>Additional Coverage Details</em>, for limits.</td>
<td></td>
</tr>
<tr>
<td>Emergency Health Services - Outpatient</td>
<td>100% after you pay a Copayment of $250 per visit</td>
</tr>
<tr>
<td>Emergency services received at a non-Network Hospital are covered at the Network level.</td>
<td></td>
</tr>
<tr>
<td>Enteral Nutrition</td>
<td>100%</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>100%</td>
</tr>
<tr>
<td>See Section 6, <em>Additional Coverage Details</em>, for limits.</td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>100%</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>--------------------------------------------------------------------</td>
</tr>
<tr>
<td>See Section 6, Additional Coverage Details, for limits.</td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td>100%</td>
</tr>
<tr>
<td>Hospital - Inpatient Stay</td>
<td>100% for services provided with a referral from your Primary Physician</td>
</tr>
<tr>
<td>Infertility Services and Fertility Solutions (FS) Program</td>
<td></td>
</tr>
<tr>
<td>Infertility services must be received by a Designated Provider.</td>
<td>Depending upon where the Covered Health Service is provided, Benefits for Infertility Services will be the same as those stated under each Covered Health Service category in this section</td>
</tr>
<tr>
<td>See Section 6, Additional Coverage Details, for limits. This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under Physician's Office Services - Sickness and Injury below.</td>
<td></td>
</tr>
<tr>
<td>Lab, X-Ray and Diagnostics - Outpatient</td>
<td></td>
</tr>
<tr>
<td>■ Lab Testing - Outpatient.</td>
<td>100%</td>
</tr>
<tr>
<td>■ X-Ray and Other Diagnostic Testing - Outpatient.</td>
<td>100%</td>
</tr>
<tr>
<td>Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</td>
<td>100%</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td></td>
</tr>
<tr>
<td>■ Inpatient.</td>
<td>100%</td>
</tr>
<tr>
<td>■ Outpatient.</td>
<td>100% after you pay a Copayment of $20 per visit</td>
</tr>
<tr>
<td>Neurobiological Disorders - Autism Spectrum Disorder Services</td>
<td></td>
</tr>
<tr>
<td>■ Inpatient.</td>
<td>100%</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------</td>
</tr>
<tr>
<td></td>
<td><em>(The Amount Payable by the Plan based on Eligible Expenses)</em></td>
</tr>
<tr>
<td></td>
<td><strong>Designated Network and Network</strong></td>
</tr>
<tr>
<td>■ Outpatient.</td>
<td>100% after you pay a Copayment of $20 per visit</td>
</tr>
<tr>
<td>Obesity Surgery</td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td>Pharmaceutical Products - Outpatient</td>
<td>100%</td>
</tr>
<tr>
<td>Physician Fees for Surgical and Medical Services</td>
<td>100% for services provided by your Primary Physician or by a Network obstetrician or gynecologist. 100% for services provided with a referral from your Primary Physician. No Benefits are payable for services provided without a referral from your Primary Physician.</td>
</tr>
<tr>
<td>Physician’s Office Services - Sickness and Injury</td>
<td>Designated Network 100%</td>
</tr>
<tr>
<td>■ Primary Physician or Specialist obstetrician or gynecologist.</td>
<td>Network 100% after you pay a Copayment of $20 per visit 100% after you pay a Copayment of $30 per visit</td>
</tr>
<tr>
<td>■ Physician Office Services (with a referral from your Primary Physician).</td>
<td>100%</td>
</tr>
<tr>
<td>■ Physician Office Services (with a referral from your Specialist Physician).</td>
<td>100%</td>
</tr>
<tr>
<td>■ Physician Office Services – Home Visits</td>
<td>100%</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>No Benefits are payable for services provided without a referral from your Primary Physician</td>
</tr>
</tbody>
</table>

In addition to the Copayment stated in this section, the Copayments and Coinsurance for the following services apply when the Covered Health Service is performed in a Physician's office:

- Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*.  
- Major diagnostic and nuclear medicine described under Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.  
- Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.  
- Outpatient surgery procedures described under *Surgery - Outpatient*.  
- Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.  

**Pregnancy - Maternity Services**

A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.

Benefits will be the same as those stated under each Covered Health Service category in this section.

For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.

**Preventive Care Services**
<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Primary Physician or Network obstetrician or gynecologist.</td>
<td>100%</td>
</tr>
<tr>
<td>■ Physician Office Services (with a referral from Primary Physician).</td>
<td>100%</td>
</tr>
<tr>
<td>■ Breast Pumps.</td>
<td>100%</td>
</tr>
<tr>
<td>■ Immunizations.</td>
<td>100%</td>
</tr>
<tr>
<td>■ Routine Scopic-Outpatient Diagnostic Therapeutic</td>
<td>100%</td>
</tr>
<tr>
<td>■ Routine Mammography</td>
<td>100%</td>
</tr>
<tr>
<td>■ Minor Lab, X-ray</td>
<td>100%</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>100%</td>
</tr>
<tr>
<td>See Section 6, <em>Additional Coverage Details</em>, for limits.</td>
<td></td>
</tr>
<tr>
<td>Reconstructive Procedures</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation Services - Outpatient Therapy and Manipulative Treatment</td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td>See Section 6, <em>Additional Coverage Details</em>, for visit limits.</td>
<td>100% after you pay a Copayment of $20 per visit for Manipulative Treatment and vision therapy services provided with a referral from your Primary Physician. No Benefits are payable for services provided without a referral from your Primary Physician.</td>
</tr>
<tr>
<td>Scopic Procedures - Outpatient Diagnostic and Therapeutic</td>
<td>100% for services provided by your Primary Physician or by a Network obstetrician or gynecologist. 100% for services provided with a referral from your Primary Physician. No Benefits are payable for services provided without a referral from your Primary Physician.</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</strong>&lt;br&gt;See Section 6, Additional Coverage Details, for limits.</td>
<td>100%</td>
</tr>
</tbody>
</table>
| **Substance-Related and Addictive Disorders Services**<br>■ Inpatient.  
■ Outpatient. | 100%  
100% after you pay a Copayment of $20 per visit |
| **Surgery - Outpatient** | 100% for services provided by your Primary Physician or by a Network obstetrician or gynecologist.  
100% for services provided with a referral from your Primary Physician. No Benefits are payable for services provided without a referral from your Primary Physician. |
<p>| <strong>Temporomandibular Joint (TMJ) Services</strong> | Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section |
| <strong>Therapeutic Treatments - Outpatient</strong> | 100% |
| <strong>Transplantation Services</strong>&lt;br&gt;Transplantation services must be received by a Designated Provider. The Claims Administrator does not require that cornea transplants be performed by a Designated Provider. | Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section |
| <strong>Urgent Care Center Services</strong>&lt;br&gt;In addition to the Copayment stated in this section, the Copayments and Coinsurance for the following services | 100% after you pay a Copayment of $50 per visit |</p>
<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</th>
</tr>
</thead>
<tbody>
<tr>
<td>apply when the Covered Health Service is performed at an Urgent Care Center:</td>
<td>Designated Network and Network</td>
</tr>
<tr>
<td>■ Lab, radiology/x-rays and other diagnostic services described under Lab, X-Ray and</td>
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<tr>
<td>Diagnostics - Outpatient.</td>
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<tr>
<td>■ Major diagnostic and nuclear medicine described under Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.</td>
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<td>■ Diagnostic and therapeutic scopic procedures described under Scopic Procedures -</td>
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<td>Outpatient Diagnostic and Therapeutic.</td>
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<td>■ Outpatient surgery procedures described under Surgery - Outpatient.</td>
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<tr>
<td>■ Outpatient therapeutic procedures described under Therapeutic Treatments - Outpatient</td>
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<tr>
<td>Virtual Visits</td>
<td>100%</td>
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<tr>
<td>Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to <a href="http://www.myuhc.com">www.myuhc.com</a> or by calling the telephone number on your ID card.</td>
<td>100%</td>
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<tr>
<td>Vision Examinations</td>
<td>100% after you pay a Copayment of $30 per visit</td>
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<td>See Section 6, Additional Coverage Details, for limits.</td>
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<td>Wigs</td>
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<td>See Section 6, Additional Coverage Details, for limits.</td>
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SECTION 6 - ADDITIONAL COVERAGE DETAILS

This section supplements the second table in Section 5, Plan Highlights.

While the table provides you with Benefit limitations along with Copayment and Coinsurance information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must obtain prior authorization from the Claims Administrator as required. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, Exclusions and Limitations.

Acupuncture Services

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

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

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

- Chemotherapy.
- Pregnancy.
- Post-operative procedures.

Benefits are limited to 12 treatments per calendar year.

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, Glossary for the definition of Emergency.

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

The Plan also covers non-Emergency transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:
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- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

**Cellular and Gene Therapy**

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician’s office.

Benefits for CAR-T therapy for malignancies are provided as described under Transplantation Services.

**Clinical Trials**

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

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

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

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

Routine patient care costs for qualifying Clinical Trials include:

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

Routine costs for Clinical Trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain Category B devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with UnitedHealthcare’s medical and drug policies.

- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

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

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

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

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

- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.

- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

- The Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial.

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

**Congenital Heart Disease (CHD) Surgeries**

The Plan pays Benefits for CHD surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding Benefits for CHD services. Contact UnitedHealthcare at the number on your ID card for information about these guidelines.

The Plan pays Benefits for CHD services ordered by a Physician and received at a facility participating in the CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under **Physician Fees for Surgical and Medical Services**.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

Benefits are available for the following CHD services:

- Outpatient diagnostic testing.
- Evaluation.
- Surgical interventions.
- Interventional cardiac catheterizations (insertion of a tubular device in the heart).
- Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology).
- Approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be proven procedures for the involved diagnoses. Contact
CHD Resource Services at 1-888-936-7246 before receiving care for information about CHD services. More information is also available at www.myoptumhealthcomplexmedical.com.

If you receive CHD services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician’s Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the CHD program, you must contact CHD Resource Services at 1-888-936-7246 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD program if CHD provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Dental Services - Accident Only

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

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

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 having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

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

- Dental services related to medical transplant procedures.
- Initiation of immunosuppressive (medication used to reduce inflammation and suppress the immune system).
Direct treatment of acute traumatic injury, cancer or cleft palate.

Dental services to repair the damage caused by accidental injury must conform to the following time-frames: Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care). Treatment must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

The Plan pays for treatment of accidental injury limited to the following:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the injury by implant, dentures or bridges.

**Diabetes Services**

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

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

Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.

*Diabetic Self-Management Items*

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under Durable Medical Equipment (DME). Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described in Section 15, Outpatient Prescription Drugs.

Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are subject to the limit stated under Durable Medical Equipment in this section.
Durable Medical Equipment (DME)

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

■ Ordered or provided by a Physician for outpatient use primarily in a home setting.
■ Used for medical purposes.
■ Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
■ Not of use to a person in the absence of a disease or disability.
■ Durable enough to withstand repeated use.

Benefits under this section include Durable Medical Equipment provided to you by a Physician. If more than one piece of DME can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

■ Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
■ Equipment to assist mobility, such as a standard wheelchair.
■ A standard Hospital-type beds.
■ Negative pressure wound therapy pumps (wound vacuums).
■ Burn garments.
■ Insulin pumps and all related necessary supplies as described under Diabetes Services in this section.
■ External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this SPD. See Hospital - Inpatient Stay, Rehabilitation Services - Outpatient Therapy and Surgery - Outpatient in this section.
■ Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage.
■ 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).
Benefits also include dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

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

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

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

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

**Emergency Health Services - Outpatient**

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

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims Administrator is notified within one business day of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Benefits will not be provided. Eligible Expenses will be determined as described under *Eligible Expenses* in Section 3, *How the Plan Works*.

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

Benefits are provided for enteral formulas and low protein modified food products, administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. Examples of conditions include:

- Metabolic diseases such as phenylketonuria (PKU) and maple syrup urine disease.
- Severe food allergies.
- Impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract.

Benefits for prescription or over-the-counter formula are available when a Physician issues a prescription or written order stating the formula or product is Medically Necessary for the therapeutic treatment of a condition requiring specialized nutrients and specifying the quantity and the duration of the prescription or order. The formula or product must be administered under the direction of a Physician or registered dietitian.

For the purpose of this Benefit, "enteral formulas" include:

- Amino acid-based elemental formulas.
- Extensively hydrolyzed protein formulas.
- Modified nutrient content formulas.

For the purpose of this Benefit, "severe food allergies" mean allergies which if left untreated will result in:

- Malnourishment.
- Chronic physical disability.
- Intellectual disability; or
  - Loss of life.

Hearing Aids

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

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

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.
Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every 3 calendar years.

**Home Health Care**

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

- Ordered by a Physician.
- Provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Not considered Custodial Care, as defined in Section 14, Glossary.
- Provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 14, Glossary for the definition of Skilled Care.

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

Benefits are limited to 6 home or office Physicians visits per month, 3 nursing visits per week and 20 hours of home health aide visits per week. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

**Hospice Care**

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

**Hospital - Inpatient Stay**

Hospital Benefits are available for:

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

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

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

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

**Infertility Services**

Therapeutic services for the treatment of infertility when provided by or under the direction of a Physician. The Plan pays Benefits for infertility when provided by a Designated Provider participating in the Fertility Solutions (FS) program. Designated Provider is defined in Section 14, Glossary.

*Note.* Diagnostic services Benefits are covered as described under Physician’s Office Services - Sickness and Injury in this section.

Benefits under this section are limited to the following procedures:

- Ovulation induction and controlled ovarian stimulation.
- Insemination procedures: Artificial Insemination (AI) and Intrauterine Insemination (IUI).
- Assisted Reproductive Technologies (ART): in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), Intra Cytoplasmic Sperm Injection (ICSI).
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm.
- Cryopreservation - embryo’s (storage is limited to 12 months).
  *Note.* Long-term storage costs (anything longer than 12 months) are not covered under the Plan.
- Pre-implantation Genetic Diagnosis (PGD) for diagnosis of genetic disorders only.
- Embryo transportation related network disruption.
- Donor coverage - associated donor medical expenses, including collection and preparation of oocyte (egg) and/or sperm, and the medications associated with the collection and preparation of oocyte and/or sperm.
  *Note.* The Plan does not cover donor charges associated with compensation or administrative services.
Fertility Preservation - when planned cancer or other medical treatment is likely to produce infertility/sterility, the plan covers the collection of sperm, cryopreservation of sperm, ovulation induction and retrieval of oocyte (egg), oocyte cryopreservation, in vitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.

To be eligible for Benefits, the Covered Person must:

■ Have failed to achieve a Pregnancy after a year of regular, unprotected intercourse if the woman is under age 35, or after six months, if the woman is over age 35.
■ Have failed to achieve Pregnancy following twelve cycles (under age 35) or six cycles (age 35 or over) of donor insemination.
■ Have failed to achieve Pregnancy due to impotence/sexual dysfunction.
■ Have infertility that is not related to voluntary sterilization.
■ Be under age 44, if female and using own oocytes (eggs).
■ Be under age 50, if female and using donor oocytes (eggs).
  Note: For treatment initiated prior to pertinent birthday, services will be covered to completion of initiated cycle.
■ Have diagnosis of a male factor causing infertility (e.g. treatment of sperm abnormalities including the surgical recovery of sperm).
■ Not a Child Dependent.

The waiting period may be waived when Covered Person has a known infertility factor, including but not limited to: congenital malformations, known male factor, known ovulatory disorders, diminished ovarian reserve, impotence/sexual dysfunction, moderate or severe endometriosis, or documented compromise of the fallopian tubes.

Benefits are limited to $100,000 per Covered Person during the entire period you are covered under the Plan. This is a combined medical and prescription drug lifetime maximum benefit.

You must obtain prior authorization from the Claims Administrator as soon as the possibility of the need for Infertility Services arises.

Lab, X-Ray and Diagnostics - Outpatient

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

■ Lab and radiology/X-ray.
■ Mammography.

Benefits under this section include:
■ The facility charge and the charge for supplies and equipment.

■ Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services.)

■ Presumptive Drug Tests and Definitive Drug Tests.

Benefits are limited to 18 Presumptive Drug Tests per calendar year.

Benefits are limited to 18 Definitive Drug Tests per calendar year.

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

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

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

Benefits under this section include:

■ The facility charge and the charge for supplies and equipment.

■ Physician services for radiologists, anesthesiologists and pathologists.

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

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

■ Inpatient treatment.

■ Residential Treatment.

■ Partial Hospitalization/Day Treatment.

■ Intensive Outpatient Treatment.

■ Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).
Services include the following:
- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for the inpatient treatment.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

**Neurobiological Disorders - Autism Spectrum Disorder Services**

The Plan pays Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Provided by a Board Certified Applied Behavior Analyst (BCBA) or other qualified provider under the appropriate supervision.
- 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 behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient Treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds). Services include the following:
- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.
- Provider-based case management services.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for the inpatient treatment.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

**Obesity Surgery**

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician provided either of the following is true:

- You have a minimum Body Mass Index (BMI) of 40.
- You have a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by obesity.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 14, Glossary and are not Experimental or Investigational or Unproven Services.

**Pharmaceutical Products - Outpatient**

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

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this SPD. Benefits for medication normally available by prescription or order or refill are provided as described under your Outpatient Prescription Drug Plan. Benefits under this section do not include medications for the treatment of infertility.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, UnitedHealthcare may direct you to a designated dispensing entity with whom UnitedHealthcare has an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health
Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a designated dispensing entity and you/your provider choose not to obtain your Pharmaceutical Product from a designated dispensing entity, Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting UnitedHealthcare at www.myuhc.com or by calling the telephone number on your ID card.

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

**Physician Fees for Surgical and Medical Services**

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

**Physician’s Office Services - Sickness and Injury**

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

Covered Health Services include medical education services that are provided in a Physician’s office by appropriately licensed or registered healthcare professionals when both of the following are true:

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

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

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

When a test is performed or a sample is drawn in the Physician’s office and then sent outside the Physician’s office for analysis or testing, Benefits for lab, radiology/X-rays and other
diagnostic services that are performed outside the Physician's office are described in Lab, X-Ray and Diagnostics - Outpatient.
Please Note
Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

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

The Plan will pay Benefits for an Inpatient Stay of at least:
- 48 hours for the mother and newborn child following a vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

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

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

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, Clinical Programs and Resources, for details.

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

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

Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on how to access Benefits for breast pumps by going to www.myuhc.com or by calling the number on your ID card. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 5, Plan Highlights, under Covered Health Services.

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

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

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

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

**Prosthetic Devices**

Benefits are paid by the Plan for external prosthetic devices that replace a limb or body part limited to:

■ Artificial arms, legs, feet and hands.
■ Artificial face, 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.

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

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

Benefits are available for repairs and replacement, except that:
There are no Benefits for repairs due to misuse, malicious damage or gross neglect.

There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

Benefits are limited to a single purchase of each type of prosthetic device every three calendar years.

Replacement Limits: At UnitedHealthcare’s discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person’s medical condition occurs sooner than the 3 year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

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

Reconstructive Procedures

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

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

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

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedures. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, Glossary.
The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a Reconstructive Procedures.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services (including habilitative services) limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy following a post-traumatic brain Injury or stroke.
- Pulmonary rehabilitation.
- Cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

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

For outpatient rehabilitation services for speech therapy, the Plan will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly. The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or stroke.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
It is ordered by a Physician and provided and administered by a licensed provider.

It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.

It requires clinical training in order to be delivered safely and effectively.

It is not Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

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

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and Residential Treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

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

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under Durable Medical Equipment and Prosthetic Devices.

Benefits are limited to:

- 20 visits per calendar year for physical therapy.
- 20 visits per calendar year for occupational therapy.
- 20 visits per calendar year for speech therapy.
- 20 visits per calendar year for pulmonary rehabilitation therapy.
- 36 visits per calendar year for cardiac rehabilitation therapy.
- 20 visits per calendar year for cognitive rehabilitation therapy.
- 20 visits per calendar year for Manipulative Treatment.
- 30 visits per calendar year for post-cochlear implant aural therapy.

**Scopic Procedures - Outpatient Diagnostic and Therapeutic**

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

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

Benefits under this section include:

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

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

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

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

**Skilled Nursing Facility/Inpatient Rehabilitation Facility Services**

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

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

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

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.
UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if both of the following are true:

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

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 dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

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

**Note:** The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 14, Glossary.

Benefits are limited to 60 days per calendar year.

**Substance-Related and Addictive Disorders Services**

Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.
Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

■ Diagnostic evaluations, assessment and treatment planning.
■ Treatment and/or procedures.
■ Medication management and other associated treatments.
■ Individual, family, and group therapy.
■ Crisis intervention.
■ Provider-based case management services.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for the inpatient treatment.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

**Surgery - Outpatient**

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

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Examples of surgical procedures performed in a Physician’s office are mole removal and ear wax removal.

Benefits under this section include:

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

**Temporomandibular Joint (TMJ) Services**

The Plan covers services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

**Diagnosis:** Examination, radiographs and applicable imaging studies and consultation.

Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:
There is clearly demonstrated radiographic evidence of significant joint abnormality.

- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations.

Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under Hospital - Inpatient Stay and Physician Fees for Surgical and Medical Services, respectively.

**Therapeutic Treatments - Outpatient**

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

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

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

Benefits under this section include:

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

**Transplantation Services**

Organ and tissue transplants including CAR-T cell therapy for malignancies when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow including CAR-T cell therapy for malignancies, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered
Health Services for which Benefits are payable through the organ recipient’s coverage under the Plan.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures must be received by a Designated Provider.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from the Claims Administrator for a cornea transplant nor is the cornea transplant required to be performed by a Designated Provider.

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

Urgent Care Center Services
The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, Glossary. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under Physician's Office Services - Sickness and Injury.

Virtual Visits
Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through live audio with video technology or audio only. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio with video communications or audio only equipment outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling the telephone number on your ID card.

Please Note: Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary.

Benefits under this section do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (CMS defined originating facilities).
Vision Examinations
The Plan pays Benefits for one routine vision exam, including refraction, to detect vision impairment by a provider in the provider's office or outpatient facility every other calendar year.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under Physician's Office Services - Sickness and Injury.

Wigs
The Plan pays Benefits for wigs and other scalp hair prosthesis regardless of the reason of hair loss.
SECTION 7 - CLINICAL PROGRAMS AND RESOURCES

What this section includes:
Health and well-being resources available to you, including:
■ Consumer Solutions and Self-Service Tools.
■ Disease Management Services.
■ Complex Medical Conditions Programs and Services.
■ Wellness Programs.
■ Women’s Health/Reproductive.

Children’s Friend believes in giving you tools to help you be an educated health care consumer. To that end, Children’s Friend has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:
■ Take care of yourself and your family members.
■ Manage a chronic health condition.
■ Navigate the complexities of the health care system.

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

Consumer Solutions and Self-Service Tools

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

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way.

If you need any assistance with the online survey, please call the number on your ID card.
Reminder Programs
To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

- Mammograms for women.
- Pediatric and adolescent immunizations.
- Cervical cancer screenings for women.
- Comprehensive screenings for individuals with diabetes.
- Influenza/pneumonia immunizations for enrollees.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

Decision Support
In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- Access to health care information.
- Support by a nurse to help you make more informed decisions in your treatment and care.
- Expectations of treatment.
- Information on providers and programs.

Conditions for which this program is available include:

- Back pain.
- Knee & hip replacement.
- Prostate disease.
- Prostate cancer.
- Benign uterine conditions.
- Breast cancer.
- Coronary disease.
- Bariatric surgery.

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

The Plan offers a second opinion service.

UnitedHealth Premium® Designation Program

To help people make more informed choices about their health care, the UnitedHealth Premium® designation program recognizes Network Physicians who meet criteria for quality and cost efficiency. UnitedHealthcare uses national standardized measures to evaluate quality. The cost efficiency criteria rely on local market benchmarks for the efficient use of resources in providing care.

For details on the UnitedHealth Premium® designation program including how to locate a Premium Care Physician, log onto www.myuhc.com or call the number on your ID card.

www.myuhc.com

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

With www.myuhc.com you can:

- Research a health condition and treatment options to get ready for a discussion with your Physician.
- Search for Network providers available in your Plan through the online provider directory.
- Complete a health survey to help you identify health habits you may improve, learn about healthy lifestyle techniques and access health improvement resources.
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area.
- Use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com

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

Visit www.myuhc.com and:

- Make real-time inquiries into the status and history of your claims.
- View eligibility and Plan Benefit information, including Copays.
- View and print all of your Explanation of Benefits (EOBs) online.
- Order a new or replacement ID card or print a temporary ID card.
Want to learn more about a condition or treatment?
Log on to www.myuhc.com and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease Management Services

Disease Management Services
If you have been diagnosed with certain chronic medical conditions you may be eligible to participate in a disease management program at no additional cost to you. The heart failure, coronary artery disease, diabetes, asthma and Chronic Obstructive Pulmonary Disease (COPD) programs are designed to support you. This means that you will receive free educational information and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- Educational materials that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications.
- Access to educational and self-management resources on a consumer website.
- An opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care.
- Access to one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
  - Education about the specific disease and condition.
  - Medication management and compliance.
  - Reinforcement of on-line behavior modification program goals.
  - Preparation and support for upcoming Physician visits.
  - Review of psychosocial services and community resources.
  - Caregiver status and in-home safety.
  - Use of mail-order pharmacy and Network providers.

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

Complex Medical Conditions Programs and Services

Cancer Resource Services (CRS) Program
Your Plan offers Cancer Resource Services (CRS) program to provide you with access to information and member assistance through a team of specialized cancer nurse consultants and access to one of the nation’s leading cancer programs.

To learn more about CRS, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card or call the program directly at 1-866-936-6002.
Coverage for oncology services and oncology-related services are based on your health plan’s terms, exclusions, limitations and conditions, including the plan’s eligibility requirements and coverage guidelines. Participation in this program is voluntary.

**Comprehensive Kidney Solution (CKS) program**

For participants diagnosed with Kidney Disease, your Plan offers the Comprehensive Kidney Solution (CKS) program to help you manage the effects of advanced Chronic Kidney Disease (CKD) through End-stage Renal Disease (ESRD).

Should the disease progress to the point of needing dialysis, CKS provides access to top-performing dialysis centers. That means you will receive treatment based on a “best practices” approach from health care professionals with demonstrated expertise.

There are hundreds of contracted dialysis centers across the country, but in situations where you cannot conveniently access a contracted dialysis center, CKS will work to negotiate patient-specific agreements on your behalf.

To learn more about Comprehensive Kidney Solutions, visit [www.myoptumhealthcomplexmedical.com](http://www.myoptumhealthcomplexmedical.com) or call the number on your ID card.

Coverage for dialysis and kidney-related services are based on your health plan’s terms, exclusions, limitations and conditions, including the plan’s eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you decide to no longer participate in the program, please contact CKS of your decision.

**Kidney Resource Services (KRS) program**

**End-Stage Renal Disease (ESRD)**

The Kidney Resource Services program provides Covered Persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS program, you’ll work with a nurse who will provide you with support and information. The nurse can help you manage other conditions, such as diabetes and high blood pressure. He or she can also help you find doctors, specialists and dialysis centers.

This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have been referred to the KRS program by your medical provider or from past claim information.

As part of your health insurance benefits, it’s available at no extra cost to you.

KRS nurse advocates are available, Monday through Friday toll-free at 1-866-561-7518 (TTY: 711).

Coverage for dialysis and kidney-related services are based on your health plan’s terms, exclusions, limitations and conditions, including the plan’s eligibility requirements and coverage guidelines. Participation in this program is voluntary.
Congenital Heart Disease (CHD) Resource Services

UnitedHealthcare provides a program that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with you and your Physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit www.myoptumhealthcomplexmedical.com or call UnitedHealthcare at the number on your ID card or you can call the CHD Resource Services Nurse Team at 888-936-7246.

Coverage for CHD surgeries and related services are based on your health plan’s terms, exclusions, limitations and conditions, including the plan’s eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD surgeries you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Service under the Plan.

Orthopedic Health Support Program

Orthopedic Health Support is a program that provides you access to specialized nurses and high-performing providers to help meet your specific needs from early pain onset through treatment and beyond.

This program offers:

- Early intervention and appropriate care.
- Coaching to support behavior change.
- Shared decision-making.
- Pre- and post-surgical counseling.
- Support in choosing treatment options.
- Education on back-related information and self-care strategies.
- Long-term support.

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

If you are considering surgery you must contact an Orthopedic nurse prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Service under the Plan.

Transplant Resource Services (TRS) Program

Your Plan offers Transplant Resource Services (TRS) program to provide you with access to one of the nation’s leading transplant programs. Receiving transplant services through this
program means your transplant treatment is based on a “best practices” approach from health care professionals with extensive expertise in transplantation.

To learn more about Transplant Resource Services, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card.

Coverage for transplant and transplant-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan’s eligibility requirements and coverage guidelines. Participation in this program is voluntary.

**Wellness Programs**

**Quit For Life Program**

UnitedHealthcare provides a tobacco cessation program to help tobacco users withdraw from nicotine dependence. The Quit For Life® program employs an evidence-based combination of physical, psychological and behavioral strategies to help enable you to take responsibility for and overcome your addiction to tobacco use.

If you are a tobacco user, the Quit For Life® program tailors a quitting plan for you and incorporates the following components:

- Multiple planned phone-based coaching sessions.
- Unlimited access to Quit Coach® staff for ongoing support for the duration of your program via toll-free phone and live chat.
- Nicotine replacement therapy (patch or gum) sent to you in conjunction with your quit date.
- Unlimited access to a mobile-friendly online web portal, including support tools that complement your phone-based coaching.
- An online Quit Guide designed to complement your phone-based coaching sessions and web activity.
- Tailored motivational emails sent throughout your quitting process.
- Personalized, interactive text messages.

If you would like to enroll in Quit For Life®, or if you would like additional information regarding the program and also how to access the program online, please call the number on your ID card.

**Women's Health/Reproductive**

**Maternity Support Program**

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get valuable educational information, advice and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:
■ Enrollment by an OB nurse.
■ Pre-conception health coaching.
■ Written and online educational resources covering a wide range of topics.
■ First and second trimester risk screenings.
■ Identification and management of at- or high-risk conditions that may impact pregnancy.
■ Pre-delivery consultation.
■ Coordination with and referrals to other benefits and programs available under the medical plan.
■ A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
■ Post-partum depression screening.

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

As a program participant, you can always call your nurse with any questions or concerns you might have.

**Neonatal Resource Services (NRS)**

NRS is a program administered by the Claims Administrator or its affiliates made available to you by the Plan Sponsor. NRS provides a dedicated team of experienced Neonatologists, Neonatal Intensive Care Unit (NICU) nurse case managers and social workers who can provide support and assistance to you and your family during your infant’s admission to the NICU. The case manager will also provide discharge planning assistance and ongoing support post-discharge based on your infant’s needs.

To take part in the NRS program you or a covered Dependent can call the Claims Administrator at the telephone number on your ID card or call NRS directly at 1-866-534-7209.

**Fertility Solutions**

Fertility Solutions is a program administered by UnitedHealthcare or its affiliates made available to you by the Plan Sponsor. The Infertility Solutions program provides:

■ Specialized clinical consulting services to Participants and Enrolled Dependents to educate on infertility treatment options.
■ Access to specialized Network facilities and Physicians for infertility services.

The Plan pays Benefits for the infertility services described above when provided by Designated Providers participating in the Fertility Solutions program. The Fertility Solutions provides education, counseling, infertility management and access to a national Network of premier infertility treatment clinics.
Covered Persons who do not live within a 60 mile radius of a Fertility Solutions Designated Provider will need to contact a Fertility Solutions case manager to determine a Network Provider prior to starting treatment. For infertility services and supplies to be considered Covered Health Services through this program, contact Fertility Solutions and enroll with a nurse consultant prior to receiving services.

You or a covered Dependent may:

- Be referred to Fertility Solutions by the Claims Administrator.
- Call the telephone number on your ID card.
- Call Fertility Solutions directly at 1-866-774-4626.

To take part in the Fertility Solutions program, call a nurse at 1-866-774-4626. The Plan will only pay Benefits under the Fertility Solutions program if Fertility Solutions provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).
SECTION 8 - EXCLUSIONS AND LIMITATIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, Additional Coverage Details.

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

When Benefits are limited within any of the Covered Health Services categories described in Section 6, Additional Coverage Details, those limits are stated in the corresponding Covered Health Service category in Section 5, Plan Highlights. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, Plan Highlights. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

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

Alternative Treatments

1. Acupressure.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, Additional Coverage Details.

Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).
This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 6, Additional Coverage Details.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

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

   - Extractions (including wisdom teeth), restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement or the Health Resources and Services Administration (HRSA) requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 6, Additional Coverage Details.

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

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 6, Additional Coverage Details.

4. Dental braces (orthodontics).

5. Treatment of congenitally missing, malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

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

2. Orthotic appliances and devices that straighten or re-shape a body part, except as described under Durable Medical Equipment (DME) in Section 6, Additional Coverage Details.
Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics and some types of braces, including orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.

3. Cranial molding helmets and cranial banding except when used to avoid the need for surgery, and/or to facilitate a successful surgical outcome.

4. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

5. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.

6. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

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


Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See Section 15, Outpatient Prescription Drugs, for coverage details and exclusions.

1. Prescription Drug Products for outpatient use that are filled by a prescription order or refill.

2. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion.

3. Non-injectable medications given in a Physician’s office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician’s office.
4. Over-the-counter drugs and treatments.

5. Growth hormone therapy.

6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 6, Additional Coverage Details.

7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

9. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

10. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

11. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

12. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

**Experimental or Investigational or Unproven Services**

1. Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or 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 or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under Clinical Trials in Section 6, Additional Coverage Details.

Foot Care
1. Routine foot care. Examples include the cutting or removal of corns and calluses.

This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 6, Additional Coverage Details.

2. Nail trimming, cutting, or debriding (removal of dead skin or underlying tissue).

3. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

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

4. Treatment of flat feet.

5. Treatment of subluxation of the foot.


7. Shoe orthotics.

8. Shoe inserts.


Medical Supplies
1. Prescribed or non-prescribed medical and disposable supplies. Examples include:
   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.
   - Ostomy supplies.

This exclusion does not apply to:
- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 6, Additional Coverage Details.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 6, Additional Coverage Details.

2. Tubings and masks except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 6, Additional Coverage Details.

**Mental Health, Neurobiological Disorders - Autism Spectrum Disorder Services and Substance-Related and Addictive Disorders Services**

In addition to all other exclusions listed in this Section 8, Exclusions and Limitations, the exclusions listed directly below apply to services described under Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services and/or Substance-Related and Addictive Disorders Services in Section 6, Additional Coverage Details.

1. Services performed in connection with conditions not classified in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association.

2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

3. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.

4. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

5. Transitional Living services.


9. High intensity residential care including American Society of Addiction Medicine (ASAM) criteria for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.
Nutrition

1. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

2. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement. This exclusion also does not apply to nutritional counseling services that are billed as Preventive Care Services or to nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

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

3. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to enteral formula and other modified food products for which Benefits are provided as described under Enteral Nutrition in Section 6, Additional Coverage Details.

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

Personal Care, Comfort or Convenience

1. Television.

2. Telephone.


4. Guest service.

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

   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps. (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement.)
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, ergonomically correct chairs, chair lifts and recliners.
   - Exercise equipment and treadmills.
   - Hot and cold compresses.
- Hot tubs.
- Humidifiers.
- Jacuzzis.
- Medical alert systems.
- Motorized beds, non-Hospital beds, comfort beds and mattresses.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Safety equipment.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 14, Glossary. Examples include:
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Sclerotherapy treatment of veins.
   - Hair removal or replacement by any means.
   - Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Skin abrasion procedures performed as a treatment for acne.
   - Treatments for hair loss.
   - Varicose vein treatment of the lower extremities, when it is considered cosmetic.

2. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 6, Additional Coverage Details.

3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation.

4. Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity.

5. Treatment of benign gynecomastia (abnormal breast enlargement in males).
Procedures and Treatments

1. Biofeedback.

2. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

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

4. Outpatient cognitive rehabilitation therapy except as Medically Necessary following traumatic brain injury or stroke.

5. Speech therapy to treat stuttering, stammering, or other articulation disorders.

6. Rehabilitation services for speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder as identified under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment in Section 6, Additional Coverage Details.

7. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.

8. Psychosurgery (lobotomy).

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

10. Chelation therapy, except to treat heavy metal poisoning.

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

12. Sex transformation operations and related services.

13. The following treatments for obesity:
   - Non-surgical treatment of obesity, even if for morbid obesity.
   - Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under Obesity Surgery in Section 6, Additional Coverage Details.

14. Medical and surgical treatment of excessive sweating (hyperhidrosis).
15. The following services for the diagnosis and treatment of temporomandibular joint syndrome (TMJ): surface electromyography, Doppler analysis, vibration analysis, computerized mandibular scan or jaw tracking, craniosacral therapy, orthodontics, occlusal adjustment, and dental restorations.

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

17. Breast reduction surgery except as coverage is required by the Women’s Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 6, Additional Coverage Details.

18. Congenital Heart Disease surgery that is not received by a Designated Provider.


Providers
1. Services performed by a provider who is a family member by birth or marriage, including your 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 ordered or delivered by a Christian Science practitioner.

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

5. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:
   - Has not been actively involved in your medical care prior to ordering the service.
   - Is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography.

Reproduction
1. The following treatment-related services:
   - Cryo-preservation and other forms of preservation of reproductive materials except as described under Infertility Services.
   - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
- Donor services and non-medical costs of oocyte or sperm donation such as donor agency fees.
- Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes.
- Natural cycle insemination in the absence of sexual dysfunction or documented congenital or acquired cervical disease or mild to moderate male factor.
- Ovulation predictor kits.

2. The following services related to Gestational Carrier or Surrogate:
   - Fees for the use of a Gestational Carrier or Surrogate.
   - Insemination costs of Surrogate or transfer embryo to Gestational Carrier, except as provided in Infertility Services under the heading Additional Benefit Coverage for Reciprocal IVF or Partner IVF.
   - IVF for a traditional Surrogate.
   - Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.

3. Cost of donor eggs and donor sperm.

4. The reversal of voluntary sterilization.

5. In vitro fertilization that is not an Assisted Reproductive Technology for the treatment of Infertility.

6. Artificial reproductive treatments done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.

7. Infertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation)

8. Infertility treatment following unsuccessful reversal of voluntary sterilization.

9. Infertility Treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis; vasectomy reversal/vasovasostomy or vasoepididymostomy).

**Services Provided under Another Plan**

Services for which coverage is available:

1. Under another plan, except for Eligible Expenses payable as described in Section 10, Coordination of Benefits (COB).

2. Under workers' compensation, or similar legislation if you could elect it, or could have it elected for you.

3. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
4. While on active military duty.

5. For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably available to you.

**Transplants**

1. Health services for organ and tissue transplants except those described under *Transplantation Services* in Section 6, *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.

2. Health services for transplants involving animal organs.

3. Transplants that are not performed by a Designated Provider. (This exclusion does not apply to cornea transplants.)

4. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Plan.)

**Travel**

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

2. Travel or transportation expenses. Additional travel expenses related to Covered Health Services received from a Designated Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 6, *Additional Coverage Details*.

**Types of Care**

1. Custodial Care or maintenance care as defined in Section 14, *Glossary* or maintenance care.

2. Domiciliary Care, as defined in Section 14, *Glossary*.

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

4. Private Duty Nursing.

5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 6, *Additional Coverage Details*.

6. Rest cures.
7. Services of personal care attendants.

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

**Vision and Hearing**

1. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants).

2. Purchase cost and associated fitting charges for eyeglasses or contact lenses.

3. 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.

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

4. Eye exercise or vision therapy.

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

**All Other Exclusions**

1. Autopsies and other coroner services and transportation services for a corpse.

2. Charges for:

   - Missed appointments.
   - Room or facility reservations.
   - Completion of claim forms.
   - Record processing.

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

4. Diagnostic tests that are:

   - Delivered in other than a Physician's office or health care facility.
   - Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests.
5. Expenses for health services and supplies:
   - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
   - That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends.
   - For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan.
   - That exceed Eligible Expenses or any specified limitation in this SPD.

6. In the event a provider waives, does not pursue, or fails to collect the Copayment, Coinsurance, any deductible or other amount owed for a particular health service, no Benefits are provided for the health service for which the Copayment, Coinsurance and/or deductible are waived.

7. Foreign language and sign language services.

8. Long term (more than 30 days) storage of blood, umbilical cord or other material.

9. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 14, Glossary. Covered Health Services are those health services including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:
   - Medically Necessary.
   - Described as a Covered Health Service in this SPD under Section 6, Additional Coverage Details and in Section 5, Plan Highlights.
   - Not otherwise excluded in this SPD under this Section 8, Exclusions and Limitations.

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

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

11. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments when:
   - Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration.
- Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under Clinical Trials in Section 6, Additional Coverage Details.
- Related to judicial or administrative proceedings or orders.
- Required to obtain or maintain a license of any type.
SECTION 9 - CLAIMS PROCEDURES

What this section includes:
■ How Network and non-Network claims work.
■ What to do if your claim is denied, in whole or in part.

Network Benefits

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

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

Non-Network Benefits

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

Prescription Drug Benefit Claims

If you wish to receive reimbursement for a prescription, you may submit a post-service claim as described in this section if:
■ You are asked to pay the full cost of the Prescription Drug Product when you fill it and you believe that the Plan should have paid for it.
■ You pay a Copay and you believe that the amount of the Copay was incorrect.

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

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting www.myuhc.com, calling the toll-free number on your ID card or contacting Human Resources. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:
■ Your name and address.
■ The patient's name, age and relationship to the Participant.
- The number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
  - A description of, and the charge for, each service.
  - The date the Sickness or Injury began.
  - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

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

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card. When filing a claim for Outpatient Prescription Drug Product Benefits, your claims should be submitted to:

Optum RX
PO Box 29077
Hot Springs, AR 71903

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

**Payment of Benefits**

When you assign your Benefits under the Plan to a non-Network provider with UnitedHealthcare's consent, and the provider submits a claim for payment, you and the provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person's agreement that the non-Network provider will be entitled to all the Covered Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that your benefit payment should be made directly to the provider, UnitedHealthcare may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If Benefits are assigned or payment to a provider is made, Children's Friend reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes Children's Friend (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan) pursuant to **Refund of Overpayments** in Section 10, **Coordination of Benefits**.
UnitedHealthcare will pay Benefits to you unless:

- The provider submits a claim form to UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider.
- You make a written request for the provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

**Form of Payment of Benefits**

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans’ recovery rights for value.

**Health Statements**

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family’s medical costs by providing claims information in easy-to-understand terms.

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

**Explanation of Benefits (EOB)**

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at www.myuhc.com. See Section 14, Glossary, for the definition of Explanation of Benefits.
Important - Timely Filing of Non-Network Claims
All claim forms for non-Network services must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

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

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

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

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

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

For urgent care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.
Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent care request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim.

Urgent 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. If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your health plan ID card. Generally, an urgent situation is when your life or health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your claim or appeal.

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

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

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

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

Note: Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor. Any Covered Person will be provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.
Federal External Review Program

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

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

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the 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 UnitedHealthcare's decision.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- 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.
- An expedited external review.

**Standard External Review**

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

- A preliminary review by UnitedHealthcare of the request.
- A referral of the request by UnitedHealthcare to the IRO.
- 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.
- 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 UnitedHealthcare’s determination. The documents include:

- All relevant medical records.
- All other documents relied upon by UnitedHealthcare.
- 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 as new and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

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


**Expedited External Review**

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

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

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual’s ability to regain maximum function and you have filed a request for an expedited internal appeal.

- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual’s ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

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

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.

- Has provided all the information and forms required so that UnitedHealthcare may process the request.

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

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant’s medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.
You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

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

- **Urgent care request for Benefits** - a request for Benefits provided in connection with urgent care services.
- **Pre-Service request for Benefits** - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-urgent care is provided.
- **Post-Service** - a claim for reimbursement of the cost of non-urgent care that has already been provided.

Please note that the decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

You may have the right to external review through an **Independent Review Organization (IRO)** upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator’s decision letter to you.

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

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

<table>
<thead>
<tr>
<th>Type of Request for Benefits or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>You do not need to submit urgent care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an urgent care request for Benefits.</td>
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</table>

### Pre-Service Request for Benefits*

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

*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.
### Post-Service Claims

<table>
<thead>
<tr>
<th>Type of Claim or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your claim is incomplete, UnitedHealthcare must notify you within:</td>
<td>30 days</td>
</tr>
<tr>
<td>You must then provide completed claim information to UnitedHealthcare within:</td>
<td>45 days</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the benefit determination:</td>
<td></td>
</tr>
<tr>
<td>■ if the initial claim is complete, within:</td>
<td>30 days</td>
</tr>
<tr>
<td>■ after receiving the completed claim (if the initial claim is incomplete), within:</td>
<td>30 days</td>
</tr>
<tr>
<td>You must appeal an adverse benefit determination no later than:</td>
<td>180 days after receiving the adverse benefit determination</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the first level appeal decision within:</td>
<td>30 days after receiving the first level appeal decision</td>
</tr>
<tr>
<td>You must appeal the first level appeal (file a second level appeal) within:</td>
<td>60 days after receiving the first level appeal decision</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the second level appeal decision within:</td>
<td>30 days after receiving the second level appeal decision</td>
</tr>
</tbody>
</table>

#### Concurrent Care Claims

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

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

#### Limitation of Action

You cannot bring any legal action against Children's Friend or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for
reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against Children's Friend 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 Children's Friend or the Claims Administrator.

You cannot bring any legal action against Children's Friend or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against Children's Friend or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against Children's Friend or the Claims Administrator.
SECTION 10 - COORDINATION OF BENEFITS (COB)

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

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:
- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, "allowable expense," is further explained below.

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

Determining Which Plan is Primary

Order of Benefit Determination Rules
If you are covered by two or more plans, the benefit payment follows the rules below in this order:
- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.
- A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent.
If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.

Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
- The parents are married or living together whether or not they have ever been married and not legally separated.
- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
- The parent with custody of the child; then
- The Spouse of the parent with custody of the child; then
- The parent not having custody of the child; then
- The Spouse of the parent not having custody of the child.

Plans for active employees pay before plans covering laid-off or retired employees.

The plan that has covered the individual claimant the longest will pay first.

Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

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

### Determining Primary and Secondary Plan - Examples

1) Let’s say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you’re covered as a Participant under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.

2) Again, let’s say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

### When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.
The Plan determines the amount it would have paid based on the allowable expense.

The Plan pays the entire difference between the allowable expense and the amount paid by the primary plan - as long as this amount is not more than the Plan would have paid had it been the only plan involved.

You will be responsible for any Copay, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the allowable expense.

**Determining the Allowable Expense If This Plan is Secondary**

<table>
<thead>
<tr>
<th>What is an allowable expense?</th>
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</thead>
<tbody>
<tr>
<td>For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.</td>
</tr>
</tbody>
</table>

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan’s network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan’s network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans’ reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When This Plan is Secondary to Medicare”.

**When a Covered Person Qualifies for Medicare**

**Determining Which Plan is Primary**

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

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

**Determining the Allowable Expense When This Plan is Secondary to Medicare**

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.
If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don’t accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program (as opposed to a provider who does not accept assignment of Medicare benefits), Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience UnitedHealthcare will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Medicare Crossover Program

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated Crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses under Part A of Medicare (hospital expenses) and to expenses under Part B (Physician office visits) and DME Medicare expenses or expenses that Medicare does not cover. You must go on to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on your ID card.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.
UnitedHealthcare does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

**Overpayment and Underpayment of Benefits**

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

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

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

**Refund of Overpayments**

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

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

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

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which UnitedHealthcare makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required
refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.
SECTION 11 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

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

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

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

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

The following persons and entities are considered third parties:

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

Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

- Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
- Providing any relevant information requested by the Plan.
- Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
- Responding to requests for information about any accident or injuries.
- Making court appearances.
- Obtaining the Plan’s consent or its agents’ consent before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

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

The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan’s first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

The Plan’s subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys’ fees, shall be deducted from the Plan’s recovery without the Plan’s express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney’s Fund Doctrine" shall defeat this right.
Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.

In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the participant, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

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

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.
Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

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

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

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

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.
SECTION 12 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end.
- How to continue coverage after it ends.

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

When your coverage ends, Children's Friend will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Your coverage under the Plan will end on the earliest of:
- The last day of the month your employment with the Company ends.
- The date the Plan ends.
- The last day of the month you stop making the required contributions.
- The last day of the month you are no longer eligible.
- The last day of the month UnitedHealthcare receives written notice from Children's Friend to end your coverage, or the date requested in the notice, if later.
- The last day of the month you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

Coverage for your eligible Dependents will end on the earliest of:
- The date your coverage ends.
- The last day of the month you stop making the required contributions.
- The last day of the month UnitedHealthcare receives written notice from Children's Friend to end your coverage, or the date requested in the notice, if later.
- The last day of the month your Dependents no longer qualify as Dependents under this Plan.

Other Events Ending Your Coverage
The Plan will provide at least thirty days' prior written notice to you that your coverage will end on the date identified in the notice if you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.
Note: If UnitedHealthcare and Children's Friend find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact, Children's Friend has the right to demand that you pay back all Benefits Children's Friend paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Dependent Child

Coverage for an unmarried enrolled Dependent child who is disabled will not end just because the child has reached a certain age. The Plan 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 or disability.
- Depends mainly on you for support.

Coverage will continue as long as the enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Plan.

The Plan will ask you to furnish proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before the Plan agrees to this extension of coverage for the child, the Plan may require that a Physician chosen by the Plan examine the child. The Plan will pay for that examination.

The Plan may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at the Plan's expense. However, the Plan will not ask for this information more than once a year.

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

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, Glossary.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if Children's Friend is subject to the provisions of COBRA.

Continuation Coverage under Federal Law (COBRA)

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

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

A Participant's enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law.

A Participant's former Spouse.

**Qualifying Events for Continuation Coverage under COBRA**

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

<table>
<thead>
<tr>
<th>If Coverage Ends Because of the Following Qualifying Events:</th>
<th>You May Elect COBRA:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For Yourself</td>
</tr>
<tr>
<td>Your work hours are reduced</td>
<td>18 months</td>
</tr>
<tr>
<td>Your employment terminates for any reason (other than gross misconduct)</td>
<td>18 months</td>
</tr>
<tr>
<td>You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage¹</td>
<td>29 months</td>
</tr>
<tr>
<td>You die</td>
<td>N/A</td>
</tr>
<tr>
<td>You divorce (or legally separate)</td>
<td>N/A</td>
</tr>
<tr>
<td>Your child is no longer an eligible family member (e.g., reaches the maximum age limit)</td>
<td>N/A</td>
</tr>
<tr>
<td>You become entitled to Medicare</td>
<td>N/A</td>
</tr>
<tr>
<td>Children's Friend files for bankruptcy under Title 11, United States Code.²</td>
<td>36 months</td>
</tr>
</tbody>
</table>
1. Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

2. This is a qualifying event for any retired Participant and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

3. From the date of the Participant's death if the Participant dies during the continuation coverage.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

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

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

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

Getting Started

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

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

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

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

- During Open Enrollment.
- Following a change in family status, as described under Changing Your Coverage in Section 2, Introduction.

**Notification Requirements**

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

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

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

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

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

**Notification Requirements for Disability Determination**

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

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 16, Important Administrative Information: ERISA. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.
Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Participant must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Participant will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

When COBRA Ends

COBRA coverage will end before the maximum continuation period, on the earliest of the following dates:

- The date, after electing continuation coverage, that coverage is first obtained under any other group health plan.
- The date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare.
- The date coverage ends for failure to make the first required premium payment (premium is not paid within 45 days).
- The date coverage ends for failure to make any other monthly premium payment (premium is not paid within 30 days of its due date).
- The date the entire Plan ends.
- The date coverage would otherwise terminate under the Plan as described in the beginning of this section.

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

Uniformed Services Employment and Reemployment Rights Act

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

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

If qualified to continue coverage pursuant to the USERRA, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period of time less than 31 days, the Participant may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

A Participant may continue Plan coverage under USERRA for up to the lesser of:

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

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

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.
SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:
■ Court-ordered Benefits for Dependent children.
■ Your relationship with UnitedHealthcare and Children's Friend.
■ Relationships with providers.
■ Interpretation of Benefits.
■ Information and records.
■ Incentives to providers and you.
■ The future of the Plan.
■ How to access the official Plan documents.

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

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

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

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

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

■ UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive. The Plan pays for Covered Health Services, which are more fully described in this SPD.
■ The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.
Children's Friend and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. Children's Friend and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. Children’s Friend and UnitedHealthcare will use de-identified data for commercial purposes including research.

**Relationship with Providers**

The Claims Administrator has agreements in place that govern the relationships between it and Children's Friend and Network providers, some of which are affiliated providers. Network providers enter into agreements with the Claims Administrator to provide Covered Health Services to Covered Persons.

Children's Friend and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, Children's Friend and UnitedHealthcare arrange for health care providers to participate in a Network and administer payment of Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not Children's Friend's employees nor are they employees of UnitedHealthcare. Children's Friend and UnitedHealthcare are not responsible for any act or omission of any provider.

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

Children's Friend is solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the service fee to UnitedHealthcare.
- The funding of Benefits on a timely basis.
- Notifying you of the termination or modifications to the Plan.

When the Plan Sponsor establishes the Plan to provide coverage under a benefit plan governed by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1001 et seq., the Claims Administrator is not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the Employee Benefits Security Administration, U. S. Department of Labor.
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 are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
■ You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
■ 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.
■ 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 Children's Friend is that of employer and employee, Dependent or other classification as defined in the SPD.

Interpretation of Benefits

Children's Friend and UnitedHealthcare have the 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, the Schedule of Benefits and any Addendums, SMMs and/or Amendments.
■ Make factual determinations related to the Plan and its Benefits.

Children's Friend and UnitedHealthcare may delegate this discretionary authority to other persons or entities including Claims Administrator’s affiliates that may provide services in regard to the administration of the Plan. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor’s and the Claims Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

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

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, 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 sources or determinations that UnitedHealthcare accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to www.myuhc.com or by calling the telephone number on your ID card.

UnitedHealthcare may apply a reimbursement methodology established by OptumInsight and/or a third party vendor, which is based on CMS coding principles, to determine appropriate reimbursement levels for Emergency Health Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use a comparable methodology(ies). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable methodology.

Information and Records

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

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

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

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

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

In some cases, as permitted by law, Children's Friend and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

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

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- A practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person’s health care is less than or more than the payment.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. Your Copayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person’s health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Services that are not
considered part of the inclusive bundled payment and those Covered Health Services would be subject to the applicable Copayment and/or Coinsurance as described in Section 5, Plan Highlights.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid 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. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You
Sometimes you may be offered coupons, enhanced Benefits, or other incentives to encourage you to participate in various wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to participate is yours alone but Children's Friend recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on your ID card if you have any questions. Additional information may be found in Section 7, Clinical Programs and Resources.

Rebates and Other Payments
Children's Friend and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. Children's Friend and UnitedHealthcare may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Copays or Coinsurance.

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

Future of the Plan
Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

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

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

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

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

Medicare Eligibility
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.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if the Plan is the secondary payer as described in Section 10, Coordination of Benefits, the Plan will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare Advantage (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When the Plan is the secondary payer, the Plan will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare Advantage plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.
SECTION 14 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Addendum - any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:
- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

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

Assisted Reproductive Technology (ART) - the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs, and/or embryos) to achieve Pregnancy. Examples of such procedures are:
- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.
Benefits - Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

BMI - see Body Mass Index (BMI).

Body Mass Index (BMI) - a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

Cancer Resource Services (CRS) - a program administered by UnitedHealthcare or its affiliates made available to you by Children's Friend. The CRS program provides:

- Specialized consulting services, on a limited basis, to Participants and enrolled Dependents with cancer.
- Access to cancer centers with expertise in treating the most rare or complex cancers.
- Education to help patients understand their cancer and make informed decisions about their care and course of treatment.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

CHD - see Congenital Heart Disease (CHD).

Claims Administrator - UnitedHealthcare (also known as United HealthCare) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial - a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA - see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services as described in Section 3, How the Plan Works and Section 15, Outpatient Prescription Drugs.

Company - Children's Friend.

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

Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited).
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy.
- Have no known cause.
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Copayment (or Copay) - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services as described in Section 3, How the Plan Works and Section 15, Outpatient Prescription Drugs.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

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

Cost-Effective - the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services - those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Service in this SPD under Section 5, Plan Highlights and 6, Additional Coverage Details and Section 15, Outpatient Prescription Drugs.
- Provided to a Covered Person who meets the Plan’s eligibility requirements, as described under Eligibility in Section 2, Introduction.
- Not otherwise excluded in this SPD under Section 8, Exclusions and Limitations or Section 15, Outpatient Prescription Drugs.

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

CRS - see Cancer Resource Services (CRS).

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.

Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

**Definitive Drug Test** - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

**Dependent** - an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as a Participant. No one can be a Dependent of more than one Participant.

**Designated Network Benefits** – for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for the Covered Health Services provided by a Physician or other provider that has been identified as a Designated Provider. Refer to Section 5, *Plan Highlights*, to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

**Designated Provider** - a provider and/or facility that:

- Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting the Claims Administrator at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card.

**Designated Virtual Network Provider** - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

**DME** - see Durable Medical Equipment (DME).

**Domestic Partner** - a person of the same or opposite sex with whom the Participant has established a Domestic Partnership.

**Domestic Partnership** - a relationship between a Participant and one other person of the same or opposite sex. All of the following requirements apply to both persons:
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- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must be at least 18 years old.
- They must share the same permanent residence and the common necessities of life.
- They must be mentally competent to enter into a contract.
- They must be financially interdependent.

Domiciliary Care - living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) - medical equipment that is all of the following:
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is not disposable.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Can withstand repeated use.
- Is not implantable within the body.
- Is appropriate for use, and is primarily used, within the home.

Eligible Expenses - for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in Section 3, How the Plan Works.

Eligible Expenses are determined solely in accordance with UnitedHealthcare’s reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare’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 UnitedHealthcare accept.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of
health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

**Emergency Health Services** - with respect to an Emergency, both of the following:

- A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

**Employee Retirement Income Security Act of 1974 (ERISA)** - the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

**Employer** - Children's Friend.

**EOB** - see Explanation of Benefits (EOB).


**Experimental or Investigational Services** - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopeia 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 I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.
Exceptions:

- Clinical Trials for which Benefits are available as described under Clinical Trials in Section 6, Additional Coverage Details.

- If you are not a participant in a qualifying Clinical Trial as described under Section 6, Additional Coverage Details, and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

**Explanation of Benefits (EOB)** - a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- The Benefits provided (if any).
- The allowable reimbursement amounts.
- Coinsurance.
- Any other reductions taken.
- The net amount paid by the Plan.
- The reason(s) why the service or supply was not covered by the Plan.

**Fertility Solutions (FS)** - a program administered by UnitedHealthcare or its affiliates made available to you by Children's Friend. The FS program provides:

- Specialized clinical consulting services to Participants and enrolled Dependents to educate on infertility treatment options.
- Access to specialized Network facilities and Physicians for infertility services.

**Freestanding Facility** - an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

**Gene Therapy** - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

**Genetic Counseling** - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.
Genetic Testing - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier - a Gestational Carrier is a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

Health Statement(s) - a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

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

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

■ It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.

■ It 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.

Hospital-based Facility - an outpatient facility that performs services and submits claims as part of a Hospital.

Infertility - A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or Therapeutic Donor Insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women age 35 years or older.

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

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

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.
**Intensive Behavioral Therapy (IBT)** - outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI)*.

**Intensive Outpatient Treatment** - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

**Intermittent Care** - skilled nursing care that is provided or needed either:
- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

**Kidney Resource Services (KRS)** - a program administered by UnitedHealthcare or its affiliates made available to you by Children's Friend. The KRS program provides:
- Specialized consulting services to Participants and enrolled Dependents with ESRD or chronic kidney disease.
- Access to dialysis centers with expertise in treating kidney disease.
- Guidance for the patient on the prescribed plan of care.

**Manipulative Treatment** - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

**Medicaid** - a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

**Medically Necessary** – health care services that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator’s sole discretion. The services must be:
- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.
Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling the number on your ID card, and to Physicians and other health care professionals on www.UHCprovider.com.

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 - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or the Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a condition is listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or 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-Related and Addictive Disorders Administrator - the organization or individual designated by Children's Friend who provides or arranges Mental Health Services and Substance-Related and Addictive Disorder Services under the Plan.

Mental Illness – those mental health or psychiatric diagnostic categories listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a condition is listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Neonatal Resource Services (NRS) - a program administered by UnitedHealthcare or its affiliates made available to you by Children's Friend. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

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.
Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

**Network Benefits** - for Benefit Plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, *Plan Highlights* to determine whether or not your Benefit plan offers Network Benefits and Section 3, *How the Plan Works*, for details about how Network Benefits apply.

**New Pharmaceutical Product** - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

**Non-Medical 24-Hour Withdrawal Management** - An organized residential service, including those defined in *American Society of Addiction Medicine (ASAM)*, providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

**Open Enrollment** - the period of time, determined by Children's Friend, during which eligible Participants may enroll themselves and their Dependents under the Plan. Children's Friend determines the period of time that is the Open Enrollment period.

**Out-of-Pocket Maximum** - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

**Partial Hospitalization/Day Treatment** - a structured ambulatory program that may be a freestanding or Hospital-based program and that provides services for at least 20 hours per week.
Participant - a full-time Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under Eligibility in Section 2, Introduction. A Participant must live and/or work in the United States.

Personal Health Support - programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Personal Health Support Nurse - the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Product(s) – U.S. Food and Drug Administration (FDA)-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

Physician - any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

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

Plan - The Children's Friend Medical Plan.

Plan Administrator - Children's Friend or its designee.

Plan Sponsor - Children's Friend.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with the above.

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

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or a home setting when any of the following are true:
Services exceed the scope of Intermittent Care in the home.

The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.

Skilled nursing resources are available in the facility.

The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

**Reconstructive Procedure** - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

**Residential Treatment** - treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility 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-Related and Addictive Disorders Services 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.
  - Referral and orientation to specialized community resources.

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

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

**Shared Savings Program** - a program in which UnitedHealthcare may obtain a discount to a non-Network provider’s billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider and a third party vendor. When this
program applies, the non-Network provider’s billed charges will be discounted. Plan
coinsurance and any applicable deductible would still apply to the reduced charge.
Sometimes Plan provisions or administrative practices supersede the scheduled rate, and a
different rate is determined by UnitedHealthcare.

This means, when contractually permitted, the Plan may pay the lesser of the Shared Savings
Program discount or an amount determined by UnitedHealthcare, such as:

- A percentage of the published rates allowed by the Centers for Medicare and Medicaid Services
  (CMS) for the same or similar service within the geographic market.
- An amount determined based on available data resources of competitive fees in that
  geographic area.
- A fee schedule established by a third party vendor.
- A negotiated rate with the provider.

In this case the non-Network provider may bill you for the difference between the billed
amount and the rate determined by UnitedHealthcare. If this happens you should call the
number on your ID Card. Shared Savings Program providers are not Network providers and
are not credentialed by UnitedHealthcare.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD
includes Mental Illness or substance-related and addictive disorders, regardless of the cause
or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, teaching, and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel
  in order to obtain the specified medical outcome and provide for the safety of the
  patient.
- A Physician orders them.
- They are not delivered for the purpose of assisting with activities of daily living,
  including dressing, feeding, bathing or transferring from a bed to a chair.
- They require clinical training in order to be delivered safely and effectively.
- They are not Custodial Care, as defined in this section.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as
required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled
Nursing Facility for purposes of the Plan.

Specialist Physician - a Physician who has a majority of his or her practice in areas other
than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general
medicine.

Spouse - an individual to whom you are legally married or a Domestic Partner as defined in
this section.
Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a disorder is listed in the edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg the surrogate is biologically (genetically) related to the child.

Therapeutic Donor Insemination (TDI) - Insemination with a donor sperm sample for the purpose of conceiving a child.

Transitional Living - Mental health services and substance-related and addictive disorders services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in American Society of Addiction Medicine (ASAM) criteria, that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

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

Unproven Services - health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.

- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care...
services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care - Care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person’s life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center - a facility 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.
SECTION 15 - OUTPATIENT PRESCRIPTION DRUGS

What this section includes:
- Benefits available for Prescription Drug Products.
- How to utilize the retail and mail order service for obtaining Prescription Drug Products.
- Any Benefit limitations and exclusions that exist for Prescription Drug Products.
- Definitions of terms used throughout this section related to the Prescription Drug Product Plan.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List (PDL) the Prescription Drug Product is listed. Refer to the Outpatient Prescription Drug Schedule of Benefits for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

What You Must Pay

Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Payment Information - Outpatient Prescription Drugs table or Schedule of Benefits - Outpatient Prescription Drugs, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your request and there is another drug that is Chemically Equivalent.

The amount you pay for any of the following under this section will not be included in calculating any Out-of-Pocket Maximum stated in your SPD:
- Copayments for Prescription Drug Products, including Specialty Prescription Drug Products.
- Coinsurance for Prescription Drug Products.
- Ancillary Charges.
- Certain coupons or offers from pharmaceutical manufacturers. You may access information on which coupons or offers are not permitted through the Internet at www.myuhc.com or by calling the telephone number on your ID card.
- 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 UnitedHealthcare contracted rates (Prescription Drug Charge) will not be available to you.

**Payment Terms and Features - Outpatient Prescription Drugs**

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

**Note:** The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 6, Additional Coverage Details.

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

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

**Prior Authorization Requirements**
Before certain Prescription Drug Products are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to obtain prior authorization from UnitedHealthcare or its designee. The reason for obtaining prior authorization from UnitedHealthcare or its designee is to determine if the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service as defined by the Plan.
- It is not an Experimental or Investigational or Unproven Service, as defined in Section 14, Glossary.
The Plan may also require you to obtain prior authorization from UnitedHealthcare or its
designee so UnitedHealthcare can determine whether the Prescription Drug Product, in
accordance with UnitedHealthcare's approved guidelines, was prescribed by a Specialist
Physician.

Network Pharmacy Prior Authorization
When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing
provider, the pharmacist, or you are responsible for obtaining prior authorization
from UnitedHealthcare.

If you do not obtain prior authorization from UnitedHealthcare before the Prescription
Drug Product is dispensed, you can ask UnitedHealthcare to consider reimbursement after
you receive the Prescription Drug Product. You will be required to pay for the Prescription
Drug Product at the pharmacy. You may seek reimbursement from the Plan as described in
Section 9, Claims Procedures.

When you submit a claim on this basis, you may pay more because you did not obtain prior
authorization from UnitedHealthcare before the Prescription Drug Product was dispensed.
The amount you are reimbursed will be based on the Prescription Drug Charge, less the
required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

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

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

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

**Benefit Information for Prescription Drug Products at a Network Pharmacy**

<table>
<thead>
<tr>
<th>Benefit Description and Supply Limits</th>
<th>Percentage of Prescription Drug Charge Payable by the Plan: (Per Prescription Order or Refill):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List (PDL) are assigned to Tier 1, Tier 2 or Tier 3. Please access <a href="http://www.myuhc.com">www.myuhc.com</a> through the Internet or call the telephone number on your ID card to determine tier status.</td>
<td>100% after you pay a:</td>
</tr>
<tr>
<td>Retail</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied.</td>
<td>$10 Copay</td>
</tr>
<tr>
<td>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed or days the drug will be delivered.</td>
<td></td>
</tr>
<tr>
<td><strong>Tier-1</strong></td>
<td>$10 Copay</td>
</tr>
<tr>
<td><strong>Tier-2</strong></td>
<td>$35 Copay</td>
</tr>
<tr>
<td><strong>Tier-3</strong></td>
<td>$60 Copay</td>
</tr>
<tr>
<td>Benefit(s) Description and Supply Limits</td>
<td>Percentage of Prescription Drug Charge Payable by the Plan: (Per Prescription Order or Refill):</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Specialty Prescription Drug Products -</td>
<td>100% after you pay a:</td>
</tr>
<tr>
<td>As written by the provider, up to a</td>
<td></td>
</tr>
<tr>
<td>consecutive 31-day supply of a Specialty</td>
<td></td>
</tr>
<tr>
<td>Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.</td>
<td></td>
</tr>
<tr>
<td>When a Specialty Prescription Drug</td>
<td></td>
</tr>
<tr>
<td>Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed or days the drug will be delivered.</td>
<td></td>
</tr>
<tr>
<td>Supply limits apply to Specialty</td>
<td></td>
</tr>
<tr>
<td>Prescription Drug Products obtained at a Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.</td>
<td></td>
</tr>
<tr>
<td>■ Tier-1</td>
<td>$10 Copay</td>
</tr>
<tr>
<td>■ Tier-2</td>
<td>$30 Copay</td>
</tr>
<tr>
<td>■ Tier-3</td>
<td>$60 Copay</td>
</tr>
<tr>
<td>Mail Order Network Pharmacy</td>
<td>100% after you pay a:</td>
</tr>
<tr>
<td>The following supply limits apply:</td>
<td></td>
</tr>
<tr>
<td>As written by the provider, up to a</td>
<td></td>
</tr>
<tr>
<td>consecutive 90-day supply of a</td>
<td></td>
</tr>
<tr>
<td>Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products, including Specialty Prescription Drug Products on the List of Preventive Medications. Specialty Prescription Drug Products from a Mail Order Network</td>
<td></td>
</tr>
<tr>
<td>Benefit&lt;sup&gt;1,2&lt;/sup&gt;</td>
<td>Description and Supply Limits</td>
</tr>
<tr>
<td>-----------------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Pharmacy are subject to the supply limits stated above under the heading <em>Specialty Prescription Drug Products</em>.</td>
</tr>
</tbody>
</table>

The Plan may allow a 31-day fill at the Mail Order Pharmacy for certain Prescription Drug Products for the Copayment and/or Coinsurance you would pay at a retail Network Pharmacy. You may determine whether a 31-day fill of Prescription Drug Product is available through the Mail Order Pharmacy for a retail Network Pharmacy Copayment and/or Coinsurance through the Internet at www.myuhc.com or by calling the telephone number on your ID card.

- **Tier-1**
  - $20 Copay

- **Tier-2**
  - $70 Copay

- **Tier-3**
  - $120 Copay

<sup>1</sup>Please obtain prior authorization from UnitedHealthcare before receiving Prescription Drug Products, as described in *Payment Terms and Features*, under *Prior Authorization Requirements* in this section.

<sup>2</sup>You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

*Note: The Coordination of Benefits provision described in Section 10, *Coordination of Benefits (COB)* applies to covered Prescription Drug Products as described in this section. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in this SPD.*

**Identification Card (ID Card) - 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 UnitedHealthcare during regular business hours.
If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

You may seek reimbursement from the Plan as described in Section 9, Claims Procedures, under the heading, If Your Provider Does Not File Your 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 Charge, less the required Copayment and/or Coinsurance, Ancillary Charge, and any deductible that applies.

Submit your claim to:

Optum Rx
PO Box 29077
Hot Spring, AR 71903

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

The Plan pays Benefits at different levels for tier-1, tier-2 and tier-3 Prescription Drug Products.

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

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

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

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of:
■ The applicable Copay.
■ The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product.
■ The Prescription Drug Charge for that Prescription Drug Product.

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

■ The applicable Copay.
■ The Prescription Drug Charge for that particular Prescription Drug.

Retail

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy. The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting UnitedHealthcare at the number on your ID card or by logging onto www.myuhc.com.

To obtain your prescription from a Network Pharmacy, simply present your ID card and pay the Copay. The 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.
■ A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay the Copay for each cycle supplied.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copay that applies will reflect the number of days dispensed.

If you purchase a Prescription Drug from a non-Network Pharmacy, you will be required to pay full price and will not receive reimbursement under the Plan.

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

Mail Order

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy. The mail order service may allow you to purchase up to a 90-day supply of a covered Prescription Drug Product through the mail from a Network Pharmacy.

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

The following supply limits apply: As written by the provider, up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.

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

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

**Benefits for Preventive Care Medications**

Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined, in this section, under *Glossary - Prescription Drug Products*. You may determine whether a drug is a Preventive Care Medication through the internet at [www.myuhc.com](http://www.myuhc.com) or by calling UnitedHealthcare at the number on your ID card.

**Designated Pharmacies**

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, UnitedHealthcare may direct you to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Prescription Drug Product.

**Smart Fill Program - Split Fill**

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Copayment or Coinsurance. The Covered Person will receive a 15-day supply of their Specialty Prescription Drug Product to determine if they will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact the Covered Person each time prior to dispensing the 15-day supply to confirm if the Covered Person is tolerating the Specialty Prescription Drug Product. You may find a list of Specialty Prescription Drug Products included in the Smart Fill Program, through the internet at [www.myuhc.com](http://www.myuhc.com) or by calling the telephone number on your ID card.

**Specialty Prescription Drug Products**

Benefits are provided for Specialty Prescription Drug Products.
If you require Specialty Prescription Drug Products, UnitedHealthcare may direct you to a Designated Pharmacy with whom UnitedHealthcare has an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Specialty Prescription Drug Product.

Please see Glossary - Outpatient Prescription Drugs, for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

Refer to the Outpatient Prescription Drug Schedule of Benefits for details on Specialty Prescription Drug Product supply limits.

Please see Glossary - Outpatient Prescription Drugs, in this section for definitions of Specialty Prescription Drug Product and Designated Pharmacy.

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

### Assigning Prescription Drug Products to the Prescription Drug List (PDL)

UnitedHealthcare's Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on UnitedHealthcare's behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are most cost effective for specific indications as compared to others, therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

The PDL Management Committee may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.
**Note:** The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access [www.myuhc.com](http://www.myuhc.com) through the Internet or call the number on your ID card for the most up-to-date tier status.

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

### Prescription Drug List (PDL)

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

### Prescription Drug Benefit Claims

For Prescription Drug Product claims procedures, please refer to Section 9, *Claims Procedures*.

### Limitation on Selection of Pharmacies

If UnitedHealthcare determines that you may be 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, UnitedHealthcare 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 don’t make a selection within 31 days of the date the Plan Administrator notifies you, UnitedHealthcare will select a single Network Pharmacy for you.

### Supply Limits

Benefits for Prescription Drug Products are subject to supply limits that are stated in the table under the heading *Prescription Drug Product Coverage Highlights*. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Whether or not a Prescription Drug Product has a supply limit is subject to UnitedHealthcare’s periodic review and modification.

**Note:** Some products are subject to additional supply limits based on criteria that the Plan Administrator and UnitedHealthcare have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month’s supply or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing, through the Internet at [www.myuhc.com](http://www.myuhc.com) or by calling the telephone number on your ID card.

### Special Programs

Children’s Friend and UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health...
management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling the number on your ID card.

**Prescription Drug Products Prescribed by a Specialist Physician**

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

**Step Therapy**

Certain Prescription Drug Products for which Benefits are described in this section are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

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

**Prescription Drug Products that are Chemically Equivalent**

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

**Rebates and Other Discounts**

UnitedHealthcare and Children's Friend may, at times, receive rebates for certain drugs included on the PDL, including those drugs that you purchase prior to meeting any applicable deductible. As determined by UnitedHealthcare, the Plan may pass a portion of these rebates on to you. When rebates are passed on to you they may be taken into account in determining your Copayment and/or Coinsurance.

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

**Coupons, Incentives and Other Communications**

At various times, UnitedHealthcare may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including
information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, at your discretion, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

**Exclusions - What the Prescription Drug Plan Will Not Cover**

Exclusions from coverage listed in Section 8, *Exclusions and Limitations* also apply to this section. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can access [www.myuhc.com](http://www.myuhc.com) through the Internet or by calling the number on your ID card for information on which Prescription Drug Products are excluded.

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

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

3. Pharmaceutical Products for which Benefits are provided in the medical (not in Section 15, *Outpatient Prescription Drugs*) portion of the Plan.

   This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

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

5. Compounded drugs that contain certain bulk chemicals. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.) Compounded drugs that are available as a similar commercially available Prescription Drug Product.

6. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.

8. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your SPD. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.


10. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

11. The amount dispensed (days’ supply or quantity limit) which exceeds the supply limit.

12. The amount dispensed (days’ supply or quantity limit) which is less than the minimum supply limit.

13. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

14. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Claims Administrator’s Prescription Drug List (PDL) Management Committee.

15. Prescribed, dispensed or intended for use during an Inpatient Stay.

16. Prescribed, dispensed for appetite suppression, and other weight loss products.

17. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that UnitedHealthcare and Children’s Friend determines do not meet the definition of a Covered Health Service.

18. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

19. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

20. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by UnitedHealthcare. Such determinations may be made up to six times during a calendar year, and
UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

21. Certain unit dose packaging or repackers of Prescription Drug Products.

22. Used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless UnitedHealthcare and Children's Friend have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in Section 14, Glossary.

23. Used for cosmetic purposes

24. General vitamins, except for the following which require a Prescription Order or Refill:
   - Prenatal vitamins.
   - Vitamins with fluoride.
   - Single entity vitamins.

25. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury.

26. A Prescription Drug Product that contains marijuana, including medical marijuana.

27. Dental products, including but not limited to prescription fluoride topicals.

28. A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

29. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

30. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

31. Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.
Glossary - Outpatient Prescription Drugs

**Ancillary Charge** - a charge, in addition to the Copayment that you are required to pay when a covered Prescription Drug Product is dispensed at your request, when a Chemically Equivalent Prescription Drug Product is available. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Product Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product, and the Prescription Drug Product Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product.

**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 UnitedHealthcare identifies as a Brand-name product, based on available data resources including, but not limited to, medi-span or 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 UnitedHealthcare.

**Chemically Equivalent** - when Prescription Drug Products contain the same active ingredient.

**Designated Pharmacy** - a pharmacy that has entered into an agreement with UnitedHealthcare or with an organization contracting on its behalf, to provide specific Prescription Drug Products including, but not limited to, Specialty Prescription Drug Products. 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 UnitedHealthcare identifies as a Generic product based on available data resources including, but not limited to, medi-span or 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 "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by UnitedHealthcare.

**Infertility** - failure to achieve a Pregnancy after a year of regular unprotected intercourse if the woman is under age 35, or after six months if the woman is over age 35. In addition, in order to be eligible for Benefits, the Covered Person must also:

- Be under age 44, if female.
- Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.

**List of Preventive Medications** - a list that identifies certain Prescription Drug Products, which may include certain Specialty Prescription Drug Products, on the Prescription Drug List (PDL) that are intended to reduce the likelihood of Sickness. You may obtain the List of Preventive Medications through the Internet at [www.myuhc.com](http://www.myuhc.com) or by calling the number on your ID card.
Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that UnitedHealthcare establishes. This list is subject to UnitedHealthcare's periodic review and modification.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with UnitedHealthcare or an organization contracting on its behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by UnitedHealthcare as a Network 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 U.S. Food and Drug Administration (FDA) and ending on the earlier of the following dates:

- The date it is assigned to a tier by UnitedHealthcare's Prescription Drug List (PDL) Management Committee.
- December 31st of the following calendar year.

Out-of-Pocket Drug Maximum - the maximum amount you are required to pay for covered Prescription Drug Products in a single year. Refer to the Outpatient Prescription Drug Benefit Information table for details about how the Out-of-Pocket Drug Maximum applies.

Prescription Drug Charge - the rate the Plan has agreed to pay UnitedHealthcare on behalf of its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

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

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

Prescription Drug Product - a medication, or product that has been approved by the U.S. Food and Drug Administration (FDA) 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 purposes of Benefits under this Plan, this definition includes:
■ Inhalers (with spacers).
■ Insulin.
■ The following diabetic supplies:
  - Standard insulin syringes with needles.
  - Blood-testing strips - glucose.
  - Urine-testing strips - glucose.
  - Ketone-testing strips and tablets.
  - Lancets and lancet devices.
  - Glucose meters including continuous glucose monitors.
  - Certain vaccines/immunizations administered in a Network Pharmacy.

**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.

**Preventive Care Medications (PPACA Zero Cost Share)** - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

■ Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.

■ 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.

You may determine whether a drug is a Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives through the internet at [www.myuhc.com](http://www.myuhc.com) or by calling UnitedHealthcare at the telephone number on your ID card.

For the purposes of this definition PPACA means Patient Protection and Affordable Care Act of 2010.

**Specialist Physician** - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

**Specialty Prescription Drug Product** - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products include certain drugs for Infertility. Specialty Prescription Drug Products may include drugs on the List of Preventive Medications. You may access a complete list of Specialty Prescription Drug Products through the Internet at [www.myuhc.com](http://www.myuhc.com) or by calling the number on your ID card.
**Therapeutically Equivalent** - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

**Usual and Customary Charge** - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.
SECTION 16 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:
- Plan administrative information, including your rights under ERISA.

This section includes information on the administration of the medical Plan, as well as information required of all Summary Plan Descriptions by ERISA as defined in Section 14, Glossary. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Administrator
Children’s Friend is the Plan Sponsor and Plan Administrator of the Children’s Friend Welfare Benefit Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Administrator - Medical Plan
Children’s Friend
153 Summer St
Providence, RI 02903
(401) 276-4324

Claims Administrator
UnitedHealthcare is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the Company. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

United Healthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

Agent for Service of Legal Process
Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Agent for Legal Process - Medical Plan
Children’s Friend
153 Summer St
Providence, RI 02903
(401) 276-4324
Legal process may also be served on the Plan Administrator.

**Other Administrative Information**
This section of your SPD contains information about how the Plan is administered as required by ERISA.

**Type of Administration**
The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

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<td>Employee and Company</td>
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<tr>
<td>Source of Benefits:</td>
<td>Assets of the Company</td>
</tr>
</tbody>
</table>

**Your ERISA Rights**
As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- Receive information about Plan Benefits.
- Examine, without charge, at the Plan Administrator’s office and at other specified worksites, all plan documents — including pertinent insurance contracts, collective bargaining agreements (if applicable), and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies. Requests for available plan documents should be sent to the address provided under *How to Appeal a Denied Claim* in Section 9, *Claims Procedures*.

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the Plan documents to understand the rules governing your COBRA continuation coverage rights.
In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under ERISA.

If your claim for a Plan Benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See Section 9, Claims Procedures, for details.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document from the Plan, and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $147 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272.
ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

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

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, the Plan provides 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.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

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

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

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

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

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your issuer.
ATTACHMENT III – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United Healthcare, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

<table>
<thead>
<tr>
<th>Claims Administrator</th>
<th>Civil Rights Coordinator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>United HealthCare Services, Inc. Civil Rights Coordinator</strong></td>
<td></td>
</tr>
<tr>
<td>UnitedHealthcare Civil Rights Grievance</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 30608</td>
<td></td>
</tr>
<tr>
<td>Salt Lake City, UT 84130</td>
<td></td>
</tr>
<tr>
<td>The toll-free member phone number listed on your health plan ID card, TTY 711</td>
<td></td>
</tr>
</tbody>
</table>

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.
You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf


Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

ATTACHMENT IV – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

<table>
<thead>
<tr>
<th>Language</th>
<th>Translated Taglines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 → Albanian</td>
<td>Ju keni të drejtë të merimi ndihmë dhe informacion filas në gjuhën tuaj. Për të kërkuar një përshtyres, telefononi në numrin që gjetet në karta e planit tuaj të shëndetësor, shtypni 0. TTY 711.</td>
</tr>
<tr>
<td>2 → Amharic</td>
<td>ይህን በማቅረብ በእንግሊዘኛ ከሁኔ ፋ牉 ያለኝ ያለው ይህን በማቅረብ ያለኝ ያለ በማቅረብ በእንግሊዘኛ ከሁኔ ያለኝ ያለ በማቅረብ በእንግሊዘኛ ከ hudone, shtypni 0. TTY 711.</td>
</tr>
<tr>
<td>5 → Bantu-Kirundi</td>
<td>Usame ubufanganiza bwa kutonka ubufasha ni amahero mu-torimisave ku bantu. Kugira usabe umusemuzi, hamagasa inomero ya telephone y’ubantu yagenere abanyangi k’i kutonze ku karangamu k’umugambirave w’ubuzima, tyeza 0. TTY 711.</td>
</tr>
<tr>
<td>6 → Bisayan-Visayan (Cebano)</td>
<td>Aduna kay katung nga manga ng-og tabang nga impensaryon sa imong lengawawe nga walya bad. Aron mahangyo og-tighubad, tawaga nga toll-free nga numero sa telefono sa miyembro nga tiakalista sa imong IBM kard sa plano sa pangawas, pandota ang 0. TTY 711.</td>
</tr>
<tr>
<td>7 → Bengali-Bangala</td>
<td>জানান যে কে মাত্র একটি জানান যে কে মাত্র একটি জানান যে কে মাত্র একটি জানান যে কে মাত্র একটি জানান যে কে মাত্র একটি জানান যে কে মাত্র একটি জানান যে কে মাত্র একটি জানান যে কে মাত্র একটি জানান যে কে মাত্র একটি জানান যে কে মাত্র একটি 5-শাখাগুলো: 3-কথা।</td>
</tr>
<tr>
<td>Language</td>
<td>Text</td>
</tr>
<tr>
<td>-------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Burmese</td>
<td>ကိုယ်ကျင်သော မိဘတ်ကြက်ကလေးများ၏ အကြောင်းအရာ ကြည့်ရှုခြင်းကို လိုအပ်၍ အဖြေများစွာပေးပါမည်။ အနုပညာ သောများကို TTY 711 ဖြင့် ပြည့်စုံသည်။</td>
</tr>
<tr>
<td>Cambodian-Mon-Khmer</td>
<td>ក្រុងព្រៃធូរសីរីភាសានុយ ប្រការីទៅកាន់ TTY 711 ឆ្នាំ 0 ។ ប្រការី 1 ។ 0 ។ 0 ។</td>
</tr>
<tr>
<td>Cherokee</td>
<td>1 ID 11 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>Chinese</td>
<td>您有權利免費以您的母語得到幫助和資訊。凡遇為一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語音通話服務直線 711 □</td>
</tr>
<tr>
<td>Choctaw</td>
<td>11 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>Cushite-Oromo</td>
<td>እወስ ከጭም ገበያ የሚያስፈር የደሀጎ የወጭ የሚያስች ይግባ ይሆ ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭም ከጭ Mohamed Baraka, 11 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>Dutch</td>
<td>U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer dat u op uw ziekteverzekeringkaart treft, druk op 0. TTY 711 □</td>
</tr>
<tr>
<td>French</td>
<td>Vous avez le droit d'obtenir gratuitement l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte de caisse du régime de soins de santé et appuyez sur la touche 0. ATS 711 □</td>
</tr>
<tr>
<td>French-Creole</td>
<td>Ou gen dwa pou twenn ed ak enfomasyon nan lang nanfason oujou. Pou mante fon interpre, sele nimevo gratuit manm lan ki endik sou hat ID plan sante ou, peze 0. TTY 711 □</td>
</tr>
</tbody>
</table>
| German            | Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an.
18. Greek

19. Gujarati

20. Hawaiian

21. Hindi

22. Hmong

23. Ibo

24. Ilocano

25. Indonesian

26. Italian

ATTACHMENT IV - GETTING HELP IN OTHER LANGUAGES OR FORMATS
CHILDREN'S FRIEND MEDICAL ASO NAVIGATE GIL MOD

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ATTACHMENT IV - GETTING HELP IN OTHER LANGUAGES OR FORMATS


<table>
<thead>
<tr>
<th>Language</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nepalese</td>
<td>तरहसित आफनै भाषामा लिने खुलासा: सहयोग जस्तो आफ्नो प्रावधान गर्न अधिकार लगाउने, तपाईंले अन्य सर्वाधिक गर्नुहोस्। सम समयमा जस्ता दोस्रोलोक सदस्यलाई सहयोग नगर्नुहोस्। TTY: 711</td>
</tr>
<tr>
<td>Nilotic-Dinka</td>
<td>Yin nang log be yi kuanye ne wërejte de thong du abac ba ci mën tu auce ke piny. Acen bi ran ye hoc ge thok thiiee, ke yin ci namba yene yup abac de ran tòg ye hoc wàir thòk to né ID kat duon de pën ak nyic; thiny 0-6-yic. TTY: 711</td>
</tr>
<tr>
<td>Norwegian</td>
<td>Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring og tai nummeret for medlemmer som er oppført på helsekortet dit tog trykk på 0. TTY: 711</td>
</tr>
<tr>
<td>Pennsylvania Dutch</td>
<td>Do hoescht de Recht fo de Helf fan Informaas in desse Spraakje, fer nit. Wann du en førstetsetrecht hat deen kaamcht du die freie Telefon-Nummer uff de Gesundheit-Bluss-ID-Kaarde yunne; dricbt 0. TTY: 711</td>
</tr>
<tr>
<td>Persian</td>
<td>نمینم می‌توانم شما نام مادکا و اطلاعاتی به عنوان جزءی از مخاطرات به روز رسانی کنم. برای دسترسی به ویکی‌پدیا، لینک برای دسترسی به ویکی‌پدیای فارسی، مخاطرات TTY: 711</td>
</tr>
<tr>
<td>Punjabi</td>
<td>ਇਹ ਦੇਸ ਦੇ ਕਲਾਤਮਕ ਸੰਘਰਸ਼ ਵਿੱਚ ਦੋਂ ਦਰਕਾਰ ਦੀਆਂ ਮੁਹਿਤਪੱਕੀ ਮੁਹਿਤਾਂ ਦੀ ਕਲਾਤਮਕ ਰੂਪਾਂ ਤੋਂ ਵਿਚਾਰ ਕੀਤਾ। ਇਹ ਕਲਾਤਮਕ ਮੁਹਿਤਾਂ ਦੀ ਸੰਘਰਸ਼ਵਾਈ ਹੈ। ਇਸ ਸੰਘਰਸ਼ਵਾਈ ਦੀ ਸੰਘਰਸ਼ਵਾਈ ਵਾਲੀ ਮੁਹਿਤਾਂ ਦੀ ਸੰਘਰਸ਼ਵਾਈ 711 ਲਈ ਲੜਕੀ, 0 ਮਾਰੇ</td>
</tr>
<tr>
<td>Polish</td>
<td>Masz prawo do uzyskania bezpłatnej informacji i pomocy w własnym języku. Po usługach tłumacza zadawam pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciąż 0. TTY: 711</td>
</tr>
<tr>
<td>Portuguese</td>
<td>Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY: 711</td>
</tr>
<tr>
<td>Romanian</td>
<td>Avei dreptul de a obtine gratuit ajutor si informatii in limba dumneavoastra. Pentru a cere un interpret, sunati la numarul de telefon gratuit care se gaseste pe cardul dumneavoastră de sanatate, apasand pe tastă 0. TTY: 711</td>
</tr>
</tbody>
</table>
| Russian | Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика.
<table>
<thead>
<tr>
<th>Language</th>
<th>Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Samoan</td>
<td>E tai oua oua e mafa atu a se feramosi ma fa'amatalaga i auaga e oua ma su e toto. I ia fa'atalovagina se tagata fa'auliiu, lukiti le telefoni mo su e le totoga o loo fisi i tua i lua poloni i lua pepea. ID mo le solia maloloia, oose le 0. TTY 711.</td>
</tr>
<tr>
<td>Setsibe-Croatian</td>
<td>Imate pravo da besplatno dobijete pomoć i informacije na Vatenskom jeziku. Da biste zatražili pomoć, nazovite besplatni broj naveden na iskaznicu Vašeg zdravstvenog osiguranja i pritisnite 0. TTY 711.</td>
</tr>
<tr>
<td>Spanish</td>
<td>Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711.</td>
</tr>
<tr>
<td>Sudanese-Fulfulde</td>
<td>Dom hakhe maadé mballeédia kadin kebía habaru ndé wóolde maadh naa ma a yóub. To o yóub puntóow, nokdu limun mu telefóol saalimáa wóolde 1D maadh ngol màmu, nyú'oo 0. TTY 711.</td>
</tr>
<tr>
<td>Swahili</td>
<td>Una haki ya kupata mpindii saa hapa hapa huku yako bila gharama. Kusama mali miini, piga mambasha waacháma ya buse iliyochodhisha kwénye TAMA kadi yako ya mpaongo wa afya. Bonyeza 0. TTY 711.</td>
</tr>
<tr>
<td>Syriac- Assyrian</td>
<td>تامه كا فلا نصيف كا فلا نصيف كا فلا نقريف لكامل في المحضر، حيث بعد ذلك تحديد النقطة من خلال ملاك في المواقع. على سبيل المثال: في منطقة تامالنة 0. TTY 711.</td>
</tr>
<tr>
<td>Tagalog</td>
<td>May kapatid kapatid ang magandang balat na impormasyon sa iyong wika saang manghahanayad. Umap-bisikling ng tagalog, tawang pagtawag sa numero ng telepono sa nakalagay sa iyong ID card ng planong panggalinggaling, pindutin sa 0. TTY 711.</td>
</tr>
<tr>
<td>Tongan</td>
<td>Oke he ma zu a totonu ke ma zu a totoni mo e u fahamatula ki ho’o lea fahafonua ta etotonga. Ke hole ha tokotala fahatonu, ta ki</td>
</tr>
<tr>
<td>Language</td>
<td>Text</td>
</tr>
<tr>
<td>----------</td>
<td>------</td>
</tr>
<tr>
<td>Fula</td>
<td>he fi koh telefoni ta' etotongi ma'ae kau memipa 'a ee 'okui lisi 'bho' kati ID kai ho'o palani ki he mu'ulele, Lomi '1 'a e 0. TTY 711</td>
</tr>
<tr>
<td>Tule</td>
<td>Miiwe mu mung om kopwene nownou ika amasou nounm ekewe aninis ika tootpw en aninis nge ekwe avwe tivi moom kapase fonoum; ese kamo. Ika ka mwochen tuogwen aninis in chakk, kon 'we member nampa, ese pwan kamo, mi vanchan won an noun health plan katen ID, inwe tii &quot;0&quot;. Ren TTY, kon 711.</td>
</tr>
<tr>
<td>Turkish</td>
<td>Kendi duzinde uzuuz oland yarum ve bilgi alma hakkiniz bulunmaktadır. Bir tercüman istemek için sağlık pl ans kimlik kartınıınız üzerine yer alan ticket siz telefon numaranızı arayınz, sonra 0'a basın. TTY (yanlıs iletişimi) için 711</td>
</tr>
<tr>
<td>Ukrainian</td>
<td>У Вас ю право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, визначений на безкоштовний номер телефону участника, зв'язаний з вашою ідентифікаційним картком плану медико-соціального страхування, натисніть 0. TTY 711</td>
</tr>
<tr>
<td>Urdu</td>
<td>اس کو اپنے زیادہ سرویس جمع کرنے کے لئے مدعو میں مکمل اطلاعات میں موجود ہتھیار کا حاملہ کا کارنامہ کے پاس پیلو تیس شمار آئے 0. TTY 711</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>Quý vị có quyền được giúp đỡ và cập thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viếng giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên tại the ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711</td>
</tr>
<tr>
<td>Yiddish</td>
<td>דעון זרי יש ביטוש עניין לעניין של מטרה addressing the Yiddish speaking community, please call TTY 711</td>
</tr>
<tr>
<td>Yoruba</td>
<td>O ni eko lati ni iranwo ati isticinileti gbà ni ede re laisanwọ. Lati bá ógbọ́ le kọ́n sí, pé só̩́í nembá ẹ̀jọ̀ ibánsí po laisanwọ ibodé ti a tó só̩́í kádi isinmọ ti étó ileere, te '0'. TTY 711</td>
</tr>
</tbody>
</table>
ADDENDUM – REAL APPEAL

This Addendum to the Plan provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.

Real Appeal

The Plan provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 18 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

These Covered Health Services will be individualized and may include, but is not limited to, the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like information regarding these Covered Health Services, you may contact the Claims Administrator through www.realappeal.com, or at the number shown on your ID card.
SUMMARY PLAN DESCRIPTION

Children's Friend
ASO Navigate GIL $750 Mod

Effective: January 1, 2021
Group Number: 753421
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SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance-Related and Addictive Disorder Administrator: 1-800-377-5154.
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 30555, Salt Lake City, UT 84130-0555.

Children’s Friend is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members under the Children’s Friend Welfare Benefit Plan. It includes summaries of:

- Who is eligible.
- Services that are covered, called Covered Health Services.
- Services that are not covered, called Exclusions and Limitations.
- How Benefits are paid.
- Your rights and responsibilities under the Plan.

This SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic SPD for this Plan.

IMPORTANT

The healthcare service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 14, Glossary.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Plan.

Children’s Friend intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice subject to any collective bargaining agreements between the Employer and various unions, if applicable. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

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

Please read this SPD thoroughly to learn how the Children’s Friend Welfare Benefit Plan works. If you have questions contact your local Human Resources department or call the number on your ID card.
How To Use This SPD

■ Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.

■ Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.

■ You can find copies of your SPD and any future amendments or request printed copies by contacting Human Resources.

■ Capitalized words in the SPD have special meanings and are defined in Section 14, Glossary.

■ If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, Glossary.

■ Children’s Friend is also referred to as Company.

■ If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.
SECTION 2 - INTRODUCTION

What this section includes:
■ Who’s eligible for coverage under the Plan.
■ The factors that impact your cost for coverage.
■ Instructions and timeframes for enrolling yourself and your eligible Dependents.
■ When coverage begins.
■ When you can make coverage changes under the Plan.

Eligibility
You are eligible to enroll in the Plan if you are a regular full-time employee who is scheduled to work at least 30 hours per week.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

■ Your Spouse, as defined in Section 14, Glossary.
■ Your or your Spouse’s child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian.
■ An unmarried child age 26 or over who is or becomes disabled and dependent upon you.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse are both covered under the Children’s Friend Welfare Benefit Plan, you may each be enrolled as a Participant or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Children’s Friend Welfare Benefit Plan, only one parent may enroll your child as a Dependent.

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, as described in Section 13, Other Important Information.

Cost of Coverage
You and Children’s Friend share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.
Note: The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of Children's Friend's cost in covering a Domestic Partner may be imputed to the Participant as income. In addition, the share of the Participant's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions.

Your contributions are subject to review and Children's Friend reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling Human Resources.

How to Enroll

To enroll, call Human Resources within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following January 1.

Important

If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact Human Resources within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once Human Resources receives your properly completed enrollment, coverage will begin on the first day of the month following your date of hire. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the date of your marriage, provided you notify Human Resources within 31 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify Human Resources within 31 days of the birth, adoption, or placement.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan. These Benefits are subject to any prior carrier's obligations under state law or contract.

You should notify UnitedHealthcare of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. For Benefit plans that have a Network...
Benefit level, Network Benefits are available only if you receive Covered Health Services from Network providers.

**Changing Your Coverage**

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- Your marriage, divorce, legal separation or annulment.
- Registering a Domestic Partner.
- The birth, legal adoption, placement for adoption or legal guardianship of a child.
- A change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan.
- Loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis.
- Your death or the death of a Dependent.
- Your Dependent child no longer qualifying as an eligible Dependent.
- A change in your or your Spouse's position or work schedule that impacts eligibility for health coverage.
- Contributions were no longer paid by the employer (this is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer).
- You or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent.
- Benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent.
- Termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact Human Resources within 60 days of termination).
- You or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact Human Resources within 60 days of the date of determination of subsidy eligibility).
- You or your Dependent lose eligibility for coverage in the individual market, including coverage purchased through a public exchange or other public market established under the Affordable Care Act (Marketplace) (other than loss of eligibility for coverage due to failure to pay premiums on a timely basis or termination of coverage for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact) regardless of whether you or your Dependent may enroll in other individual market coverage, through or outside of a Marketplace.
A strike or lockout involving you or your Spouse.

A court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact Human Resources within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Change in Family Status - Example

Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in Children's Friend's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under Children's Friend's medical plan outside of annual Open Enrollment.
SECTION 3 - HOW THE PLAN WORKS

What this section includes:
- Selecting a Primary Physician.
- Accessing Benefits.
- Eligible Expenses.
- Annual Deductible.
- Copayment.
- Coinsurance.
- Out-of-Pocket Maximum.

Selecting a Network Primary Physician

As a participant in this Plan, you must select a Network Primary Physician, who is located in the geographic area of the permanent residence of the Participants, in order to obtain Benefits. In general health care terminology, a Primary Physician may also be referred to as a Primary Care Physician or PCP. A Network Primary Physician will be able to coordinate all Covered Health Services and submit electronic referrals online to UnitedHealthcare for services from Network Physicians. If you are the custodial parent of an enrolled Dependent child, you must select a Network Primary Physician, who is located in the geographic area of the permanent residence of the Participants, for that child. If you do not select a Network Primary Physician for yourself or your enrolled Dependent child, one will be assigned.

You may select any Network Primary Physician who is located in the geographic area of the permanent residence of the Participants and is accepting new patients. You may designate a Network Physician who specializes in pediatrics (including pediatric subspecialties, based on the scope of that provider's license under applicable state law) as the Network Primary Physician for an enrolled Dependent child. For obstetrical or gynecological care, you do not need a referral from a Network Primary Physician and may seek care directly from any Network Physician who specializes in obstetrics or gynecology.

You can obtain a list of Network Primary Physicians and/or Network obstetricians and gynecologist by contacting UnitedHealthcare at the number on your ID card or logging onto www.myuhc.com.

You may change your Network Primary Physician by calling the telephone number shown on your ID card or by logging onto www.myuhc.com. Changes are permitted once per month. Changes submitted on or before the 15th of the month will be effective on the first day of the following month. Changes submitted on or after the 16th of the month will be effective on the first day of the second following month.

Covered Health Services must be provided by or referred by your Primary Physician. If care from another Network Physician is needed, your Primary Physician will provide you with a referral. The referral must be received before the services are rendered.
IMPORTANT
If you see a Network Physician without a referral from your Primary Physician, Benefits will not be paid. You do not need a referral to see an obstetrician/gynecologist or to receive services through the Mental Health/Substance-Related and Addictive Disorders Services Administrator.

Accessing Benefits
UnitedHealthcare Navigate offers a limited Network of providers. To obtain Benefits, you must receive Covered Health Services from a UnitedHealthcare Navigate Network provider. You can confirm that your provider is a UnitedHealthcare Navigate Network provider by calling the telephone number on your ID card or you can access a directory of providers online at www.myuhc.com.

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this SPD, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

You should confirm that your provider is a UnitedHealthcare Designated Network Benefits or Navigate Network provider, including when receiving Covered Health Services for which you received a referral from your Primary Physician.

Designated Network Benefits apply to Covered Health Services that are provided by a Network Physician or other provider that is identified as a Designated Provider. Only certain Physicians and providers have been identified as a Designated Provider. Designated Network Benefits are available only for specific Covered Health Services as identified in Section 5, Plan Highlights.

When Designated Network Benefits apply, they are included in and subject to the same Annual Deductible and Out-of-Pocket Maximum requirements as all other Covered Health Services provided by Network providers.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Benefits for facility services apply when Covered Health Services are provided at a Network facility. Benefits include Physician services provided in a Network facility by a Network or a non-Network radiologist, anesthesiologist, pathologist, Emergency room Physician and consulting Physician. Benefits also include Emergency Health Services.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare’s Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program in Section 14, Glossary, of the SPD for details about how the Shared Savings Program applies.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way
of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

**Network Providers**

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

Network providers are independent practitioners and are not employees of Children's Friend or UnitedHealthcare. It is your responsibility to select your provider.

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

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 UnitedHealthcare. A directory of providers is available online at www.myuhc.com or by calling the number on your ID card to request a copy.

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 Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact the number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of UnitedHealthcare’s products. Refer to your provider directory or contact UnitedHealthcare for assistance.

**Health Services from Non-Network Providers**

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from a non-Network provider. In this situation, your Network Physician will notify the Claims Administrator, and if the Claims Administrator confirms that care is not available from a Network provider, the Claims Administrator will work with you and your Network Physician to coordinate care through a non-Network provider.
When you receive Covered Health Services through a Network Physician, the Plan will pay Network Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a non-Network provider.

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

**Possible Limitations on Provider Use**
If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to provide and coordinate all of your future Covered Health Services.

If you don’t make a selection within 31 days of the date you are notified, UnitedHealthcare will select a single Network Physician for you.

In the event that you do not use the selected Network Physician, Benefits will not be paid.

**Designated Providers**
If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Provider chosen by UnitedHealthcare. If you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Provider, UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare’s discretion.

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

You or your Network Physician must notify UnitedHealthcare of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify UnitedHealthcare in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Provider) or other non-Network provider, Benefits will not be paid.

**Additional Network Availability**
 Certain Covered Health Services defined below may also be provided through the W500 Network. Go to [www.myuhc.com](http://www.myuhc.com) or contact UnitedHealthcare for the W500 provider directory. You are eligible for Benefits when these certain Covered Health Services are received from providers who are contracted with UnitedHealthcare through the W500 Network.
These Covered Health Services are limited to the services listed below, as described in Section 6, Additional Coverage Details:

- Emergency Health Services - Outpatient.
- Hospital - Inpatient Stay, when you are admitted to the Hospital on an unscheduled basis because of an Emergency. Benefits for services provided while you are confined in a Hospital also include Covered Health Services as described under Physician Fees for Surgical and Medical Services.
- Urgent care services provided as described under Urgent Care Center Services. Urgent care services are those 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.

Also, if UnitedHealthcare determines that specific Covered Health Services are not available from a Navigate Network provider, you may be eligible for Benefits when Covered Health Services are received from a W500 Network provider. In this situation, before you receive these Covered Health Services, your Navigate Network Physician will notify UnitedHealthcare and, if UnitedHealthcare confirms that the Covered Health Services are not available from a Navigate Network provider, UnitedHealthcare will work with you and your Navigate Network Physician to coordinate these Covered Health Services through a W500 Network provider.

**Eligible Expenses**

Children's Friend has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

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

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

- When Covered Health Services are received from a Designated Network Benefits and Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.
Don’t Forget Your ID Card
Remember to show your ID card every time you receive health care services from a Network provider. If you do not show your ID card, a Network provider has no way of knowing that you are enrolled under the Plan.

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

The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, Outpatient Prescription Drugs. The Annual Deductible for Designated Network and Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drug products provided in Section 15, Outpatient Prescription Drugs.

This Plan includes an Annual Deductible that applies to certain Covered Health Services. Refer to Section 5, Plan Highlights, for details about the specific Covered Health Services to which the Annual Deductible applies.

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

The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear in this section under the heading Eligible Expenses.

Copayment
A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is calculated as a flat dollar amount and is paid at the time of service or when billed by the provider. When Copayments apply, the amount is listed in Section 5, Plan Highlights, next to the description for each Covered Health Service.

Please note that for Covered Health Services, you are responsible for paying the lesser of:

- The applicable Copayment.
- The Eligible Expense.

Details about the way in which Eligible Expenses are determined appear in this section under the heading Eligible Expenses.

Copays count toward the Out-of-Pocket Maximum. Copays do not count toward the Annual Deductible. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.
**Coinsurance**

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear in this section under the heading Eligible Expenses.

**Out-of-Pocket Maximum**

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

The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, as indicated in the table below, including Covered Health Services provided in Section 15, *Outpatient Prescription Drugs*. The Out-of-Pocket Maximum for Designated Network and Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drug products provided in Section 15, *Outpatient Prescription Drugs*.

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

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Applies to the Out-of-Pocket Maximum?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copays, even those for Covered Health Services available in Section 15, <em>Outpatient Prescription Drugs</em></td>
<td>Yes</td>
</tr>
<tr>
<td>Payments toward the Annual Deductible</td>
<td>Yes</td>
</tr>
<tr>
<td>Coinsurance Payments, even those for Covered Health Services available in Section 15, <em>Outpatient Prescription Drugs</em></td>
<td>Yes</td>
</tr>
<tr>
<td>Charges for non-Covered Health Services</td>
<td>No</td>
</tr>
<tr>
<td>Ancillary or Therapeutically Equivalent Charges described in Section 15, <em>Outpatient Prescription Drugs</em></td>
<td>No</td>
</tr>
</tbody>
</table>
SECTION 4 - PERSONAL HEALTH SUPPORT AND PRIOR AUTHORIZATION

What this section includes:
- An overview of the Personal Health Support program.
- Covered Health Services which Require Prior Authorization.

Care Management

When you seek prior authorization as required, the Claims Administrator will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

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

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

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

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. When the Claims Administrator is called as required, they will work with you to implement the Personal Health Support process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. As of the publication of this SPD, the Personal Health Support program includes:

- **Admission counseling** - Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on your ID card for support.

- **Inpatient care management** - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.

- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or
follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.

- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant’s specific chronic or complex condition.

- **Cancer Management** - You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path.

- **Kidney Management** - You have the opportunity to engage with a nurse that specializes in kidney disease, education and guidance with CKD stage 4/5 or ESRD throughout your care path.

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

**Prior Authorization**

UnitedHealthcare requires prior authorization for certain Covered Health Services. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization.

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

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

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

**Contacting UnitedHealthcare or Personal Health Support is easy.** Simply call the number on your ID card.
Services for which you are required to obtain prior authorization are identified in Section 6, Additional Coverage Details within each Covered Health Service Benefit description. Please note that prior authorization timelines apply. Refer to the applicable Benefit description to determine how far in advance you must obtain prior authorization and any applicable reductions in Benefits.

Please note that prior authorization is required even if you have a referral from your Primary Physician to seek care from another Network Physician.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Plan pays Benefits) the prior authorization requirements do not apply to you. Since Medicare is the primary payer, the Plan will pay as secondary payer as described in Section 10, Coordination of Benefits (COB). You are not required to obtain authorization before receiving Covered Health Services.
SECTION 5 - PLAN HIGHLIGHTS

What this section includes:
- Payment Terms and Features.
- Schedule of Benefits.

Payment Terms and Features

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

<table>
<thead>
<tr>
<th>Plan Features</th>
<th>Designated Network and Network Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Copays</strong></td>
<td></td>
</tr>
<tr>
<td>In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages.</td>
<td></td>
</tr>
<tr>
<td>■ Emergency Health Services.</td>
<td>$250 Designated Network</td>
</tr>
<tr>
<td>■ Physician's Office Services - Primary Physician.</td>
<td>$0 Designated Network</td>
</tr>
<tr>
<td>■ Physician's Office Services - Specialist.</td>
<td>$0</td>
</tr>
<tr>
<td>■ Rehabilitation Services.</td>
<td>$20 Network</td>
</tr>
<tr>
<td>■ Urgent Care Center Services.</td>
<td>$50</td>
</tr>
<tr>
<td>■ Physician's Office Services - Primary Physician.</td>
<td>$30 Network</td>
</tr>
<tr>
<td>■ Physician's Office Services - Specialist.</td>
<td>$20</td>
</tr>
<tr>
<td>Plan Features</td>
<td>Designated Network and Network Amounts</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Copays do not apply toward the Annual Deductible. Copays apply toward the Out-of-Pocket Maximum.</td>
<td></td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td></td>
</tr>
<tr>
<td>■ Individual.</td>
<td>$750</td>
</tr>
<tr>
<td>■ Family (not to exceed the applicable Individual amount for all Covered Persons in a family).</td>
<td></td>
</tr>
<tr>
<td><strong>Coupons:</strong> The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.</td>
<td>$1,500</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td></td>
</tr>
<tr>
<td>■ Individual.</td>
<td>$1,500</td>
</tr>
<tr>
<td>■ Family (not to exceed the applicable Individual amount for all Covered Persons in a family).</td>
<td>$3,000</td>
</tr>
<tr>
<td>The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.</td>
<td></td>
</tr>
<tr>
<td>The Annual Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, <em>Outpatient Prescription Drugs</em>.</td>
<td></td>
</tr>
<tr>
<td><strong>Coupons:</strong> The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Out-of-Pocket Maximum.</td>
<td></td>
</tr>
<tr>
<td><strong>Lifetime Maximum Benefit</strong></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Plan Features</td>
<td>Designated Network and Network Amounts</td>
</tr>
<tr>
<td>---------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>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-related and addictive disorders services (including behavioral health treatment); prescription drug products; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care).</td>
<td></td>
</tr>
</tbody>
</table>

**Schedule of Benefits**

This table provides an overview of the Plan’s coverage levels. For detailed descriptions of your Benefits, refer to Section 6, Additional Coverage Details.

<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Benefit (The Amount Payable by the Plan based on Eligible Expenses)</th>
<th>Designated Network and Network Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acupuncture Services</strong></td>
<td>100% after you meet the Annual Deductible</td>
<td></td>
</tr>
<tr>
<td>See Section 6, Additional Coverage Details, for limits.</td>
<td>No Benefits are payable for services provided without a referral from your Primary Physician.</td>
<td></td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
<td>Copayment of $50 then 100% after you meet the Annual Deductible</td>
<td></td>
</tr>
<tr>
<td>■ Emergency Ambulance- Ground</td>
<td>100% after you meet the Annual Deductible</td>
<td></td>
</tr>
<tr>
<td>■ Emergency Ambulance- Air</td>
<td>100% after you meet the Annual Deductible</td>
<td></td>
</tr>
<tr>
<td>■ Non-Emergency Ambulance-Ground</td>
<td>Copayment of $50 then 100% after you meet the Annual Deductible</td>
<td></td>
</tr>
</tbody>
</table>
### Covered Health Services

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Designated Network and Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-Emergency Ambulance-Air</strong></td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Ground or air ambulance, as the Claims Administrator determines appropriate.</td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td><strong>Cellular and Gene Therapy</strong></td>
<td></td>
</tr>
<tr>
<td>Services must be received at a Designated Provider.</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Trials</strong></td>
<td></td>
</tr>
<tr>
<td>Benefits are available when the Covered Health Services are provided by either Network or non-Network providers.</td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td><strong>Congenital Heart Disease (CHD) Surgeries</strong></td>
<td>100% after you meet the Annual Deductible for services provided with a referral from your Primary Physician</td>
</tr>
<tr>
<td><strong>Dental Services - Accident Only</strong></td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Diabetes Services</strong></td>
<td></td>
</tr>
<tr>
<td>Diabetes Self-Management and Training/ Diabetic Eye Examinations/ Foot Care</td>
<td>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td>Diabetes Self-Management Items</td>
<td>Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under Durable Medical Equipment</td>
</tr>
<tr>
<td><strong>Diabetes Self-Management Items</strong></td>
<td></td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Benefit</strong> <em>(The Amount Payable by the Plan based on Eligible Expenses)</em></td>
<td><strong>Designated Network and Network</strong></td>
</tr>
<tr>
<td></td>
<td>in this section and in Section 15, <em>Outpatient Prescription Drugs.</em></td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>See Section 6, <em>Additional Coverage Details,</em> for limits.</td>
<td></td>
</tr>
<tr>
<td>Emergency Health Services - Outpatient</td>
<td>100% after you pay a Copayment of $250 per visit</td>
</tr>
<tr>
<td>Emergency services received at a non-Network Hospital are covered at the Network level.</td>
<td></td>
</tr>
<tr>
<td>If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.</td>
<td></td>
</tr>
<tr>
<td>Enteral Nutrition</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>See Section 6, <em>Additional Coverage Details,</em> for limits.</td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>See Section 6, <em>Additional Coverage Details,</em> for limits.</td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Hospital - Inpatient Stay</td>
<td>100% after you meet the Annual Deductible for services provided with a referral from your Primary Physician</td>
</tr>
<tr>
<td>Infertility Services and Fertility Solutions (FS) Program</td>
<td></td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Infertility services must be received by a Designated Provider.</td>
<td>Depending upon where the Covered Health Service is provided, Benefits for Infertility Services will be the same as those stated under each Covered Health Service category in this section</td>
</tr>
<tr>
<td>See Section 6, Additional Coverage Details, for limits. This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under Physician’s Office Services - Sickness and Injury below.</td>
<td></td>
</tr>
<tr>
<td>Lab, X-Ray and Diagnostics - Outpatient</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Lab Testing - Outpatient.</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ X-Ray and Other Diagnostic Testing - Outpatient.</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Inpatient.</td>
<td>100% after you pay a Copayment of $20 per visit</td>
</tr>
<tr>
<td>■ Outpatient.</td>
<td>100% after you pay a Copayment of $20 per visit</td>
</tr>
<tr>
<td>Neurobiological Disorders - Autism Spectrum Disorder Services</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Inpatient.</td>
<td>100% after you pay a Copayment of $20 per visit</td>
</tr>
<tr>
<td>■ Outpatient.</td>
<td>100% after you pay a Copayment of $20 per visit</td>
</tr>
<tr>
<td>Obesity Surgery</td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td>Ostomy Supplies</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Pharmaceutical Products - Outpatient</strong></td>
<td>Designated Network and Network</td>
</tr>
<tr>
<td></td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td><strong>Physician Fees for Surgical and Medical Services</strong></td>
<td>Designated Network and Network</td>
</tr>
<tr>
<td></td>
<td>100% after you meet the Annual Deductible for services provided by your Primary Physician or by a Network obstetrician or gynecologist.</td>
</tr>
<tr>
<td></td>
<td>100% after you meet the Annual Deductible for services provided with a referral from your Primary Physician. No Benefits are payable for services provided without a referral from your Primary Physician.</td>
</tr>
<tr>
<td><strong>Physician’s Office Services - Sickness and Injury</strong></td>
<td>Designated Network and Network</td>
</tr>
<tr>
<td>■ Primary Physician or Specialist Physician obstetrician or gynecologist.</td>
<td>Designated Network and Network</td>
</tr>
<tr>
<td>■ Physician Office Services (with a referral from your Primary Physician).</td>
<td>Designated Network and Network</td>
</tr>
<tr>
<td>■ Physician Office Services (with a referral from your Specialist Physician).</td>
<td>Designated Network and Network</td>
</tr>
<tr>
<td>■ Physician Office Services – Home Visits.</td>
<td>Designated Network and Network</td>
</tr>
<tr>
<td></td>
<td>100% after you meet the deductible.</td>
</tr>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td></td>
<td>100% after you pay a Copayment of $20 per visit after you meet the deductible.</td>
</tr>
<tr>
<td></td>
<td>Designated Network and Network</td>
</tr>
<tr>
<td></td>
<td>100% after you pay a Copayment of $30 per visit after you meet the deductible.</td>
</tr>
<tr>
<td></td>
<td>Network</td>
</tr>
<tr>
<td></td>
<td>100% after you meet the deductible.</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------</td>
</tr>
<tr>
<td></td>
<td><em>(The Amount Payable by the Plan based on Eligible Expenses)</em></td>
</tr>
<tr>
<td></td>
<td>Designated Network and Network</td>
</tr>
</tbody>
</table>

In addition to the Copayment stated in this section, the Copayments and Coinsurance and any Deductible for the following services apply when the Covered Health Service is performed in a Physician's office:

- Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostics - Outpatient*.
- Major diagnostic and nuclear medicine described under Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.
- Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*.
- Outpatient surgery procedures described under *Surgery - Outpatient*.
- Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*.

**Pregnancy - Maternity Services**
A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.

Benefits will be the same as those stated under each Covered Health Service category in this section.

For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.

**Preventive Care Services**
<table>
<thead>
<tr>
<th>Covered Health Services</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Primary Physician or Network obstetrician or gynecologist.</td>
<td>100%</td>
</tr>
<tr>
<td>■ Physician Office Services (with a referral from Primary Physician).</td>
<td>100%</td>
</tr>
<tr>
<td>■ Breast Pumps.</td>
<td>100%</td>
</tr>
<tr>
<td>■ Immunizations.</td>
<td>100%</td>
</tr>
<tr>
<td>■ Routine Scopic-Outpatient Diagnostic Therapeutic</td>
<td>100%</td>
</tr>
<tr>
<td>■ Routine Mammography</td>
<td>100%</td>
</tr>
<tr>
<td>■ Minor Lab, X-ray</td>
<td>100%</td>
</tr>
<tr>
<td>■ Prosthetic Devices</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Reconstructive Procedures</td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
<tr>
<td>■ Rehabilitation Services - Outpatient Therapy and Manipulative Treatment</td>
<td>$20 Copayment then 100% after you meet the Annual Deductible per visit for Manipulative Treatment and vision therapy services provided with a referral from your Primary Physician. No Benefits are payable for services provided without a referral from your Primary Physician.</td>
</tr>
<tr>
<td>■ Scopic Procedures - Outpatient Diagnostic and Therapeutic</td>
<td>100% after you meet the Annual Deductible for services provided by your Primary Physician or by a Network obstetrician or gynecologist. 100% after you meet the Annual Deductible for services provided with a referral from your Primary Physician. No</td>
</tr>
<tr>
<td>Covered Health Services</td>
<td>Benefit</td>
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<td>-------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
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<tr>
<td></td>
<td><em>(The Amount Payable by the Plan based on Eligible Expenses)</em></td>
</tr>
<tr>
<td></td>
<td><strong>Designated Network and Network</strong></td>
</tr>
<tr>
<td></td>
<td>Benefits are payable for services provided without a referral from your Primary Physician.</td>
</tr>
<tr>
<td>Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>See Section 6, <em>Additional Coverage Details</em>, for limits.</td>
<td></td>
</tr>
<tr>
<td>Substance-Related and Addictive Disorders Services</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>■ Inpatient.</td>
<td>100% after you pay a Copayment of $20 per visit</td>
</tr>
<tr>
<td>■ Outpatient.</td>
<td></td>
</tr>
<tr>
<td>Surgery - Outpatient</td>
<td>100% after you meet the Annual Deductible for services provided by your Primary Physician or by a Network obstetrician or gynecologist.</td>
</tr>
<tr>
<td></td>
<td>100% after you meet the Annual Deductible for services provided with a referral from your Primary Physician. No Benefits are payable for services provided without a referral from your Primary Physician.</td>
</tr>
<tr>
<td>Temporomandibular Joint (TMJ) Services</td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section</td>
</tr>
<tr>
<td>Therapeutic Treatments - Outpatient</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
<tr>
<td>Transplantation Services</td>
<td>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.</td>
</tr>
</tbody>
</table>
| Covered Health Services | Benefit  
*(The Amount Payable by the Plan based on Eligible Expenses)* |
<table>
<thead>
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<tbody>
<tr>
<td></td>
<td>Designated Network and Network</td>
</tr>
<tr>
<td>Transplants</td>
<td>Transplants be performed by a Designated Provider.</td>
</tr>
<tr>
<td>Urgent Care Center Services</td>
<td>100% after you pay a Copayment of $50 per visit</td>
</tr>
<tr>
<td>Virtual Visits</td>
<td>Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to <a href="http://www.myuhc.com">www.myuhc.com</a> or by calling the telephone number on your ID card. 100%</td>
</tr>
<tr>
<td>Vision Examinations</td>
<td>100% after you pay a Copayment of $20 per visit</td>
</tr>
<tr>
<td>Wigs</td>
<td>100% after you meet the Annual Deductible</td>
</tr>
</tbody>
</table>
SECTION 6 - ADDITIONAL COVERAGE DETAILS

This section supplements the second table in Section 5, Plan Highlights.

While the table provides you with Benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must obtain prior authorization from the Claims Administrator as required. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, Exclusions and Limitations.

Acupuncture Services

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

■ Doctor of Medicine.
■ Doctor of Osteopathy.
■ Chiropractor.
■ Acupuncturist.

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

■ Chemotherapy.
■ Pregnancy.
■ Post-operative procedures.

Benefits are limited to 12 treatments per calendar year.

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, Glossary for the definition of Emergency.

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

The Plan also covers non-Emergency transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:
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- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

**Cellular and Gene Therapy**

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under Transplantation Services.

**Clinical Trials**

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

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

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

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

Routine patient care costs for qualifying Clinical Trials include:

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

Routine costs for Clinical Trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - Certain Category B devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with UnitedHealthcare’s medical and drug policies.

- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI)).
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA).
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  - The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the National Institutes of Health.
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♦ Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

■ The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.

■ The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

■ The Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial.

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

**Congenital Heart Disease (CHD) Surgeries**

The Plan pays Benefits for CHD surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding Benefits for CHD services. Contact UnitedHealthcare at the number on your ID card for information about these guidelines.

The Plan pays Benefits for CHD services ordered by a Physician and received at a facility participating in the CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under **Physician Fees for Surgical and Medical Services**.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

Benefits are available for the following CHD services:

■ Outpatient diagnostic testing.

■ Evaluation.

■ Surgical interventions.

■ Interventional cardiac catheterizations (insertion of a tubular device in the heart).

■ Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology).

■ Approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be proven procedures for the involved diagnoses. Contact
CHD Resource Services at 1-888-936-7246 before receiving care for information about CHD services. More information is also available at www.myoptumhealthcomplexmedical.com.

If you receive CHD services from a facility that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury.
- Physician Fees for Surgical and Medical Services.
- Scopic Procedures - Outpatient Diagnostic and Therapeutic.
- Therapeutic Treatments - Outpatient.
- Hospital - Inpatient Stay.
- Surgery - Outpatient.

To receive Benefits under the CHD program, you must contact CHD Resource Services at 1-888-936-7246 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD program if CHD provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

**Dental Services - Accident Only**

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

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

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 having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

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

- Dental services related to medical transplant procedures.
- Initiation of immunosuppressive (medication used to reduce inflammation and suppress the immune system).
■ Direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental services to repair the damage caused by accidental Injury must conform to the following time-frames: Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care), Treatment must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Plan.

The Plan pays for treatment of accidental Injury limited to the following:

■ Emergency examination.
■ Necessary diagnostic X-rays.
■ Endodontic (root canal) treatment.
■ Temporary splinting of teeth.
■ Prefabricated post and core.
■ Simple minimal restorative procedures (fillings).
■ Extractions.
■ Post-traumatic crowns if such are the only clinically acceptable treatment.
■ Replacement of lost teeth due to the Injury by implant, dentures or bridges.

**Diabetes Services**

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

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

Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.

*Diabetic Self-Management Items*

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under Durable Medical Equipment (DME). Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described in Section 15, *Outpatient Prescription Drugs*.

Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment* in this section.
Durable Medical Equipment (DME)

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

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.
- Durable enough to withstand repeated use.

Benefits under this section include Durable Medical Equipment provided to you by a Physician. If more than one piece of DME can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type beds.
- Negative pressure wound therapy pumps (wound vacuums).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under Diabetes Services in this section.
- External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this SPD. See Hospital - Inpatient Stay, Rehabilitation Services - Outpatient Therapy and Surgery - Outpatient in this section.
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage.
- 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).
Benefits also include dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three-month rental period.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

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

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

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

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

**Emergency Health Services - Outpatient**

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

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims Administrator is notified within one business day of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Benefits will not be provided. Eligible Expenses will be determined as described under *Eligible Expenses* in Section 3, *How the Plan Works*.

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

Benefits are provided for enteral formulas and low protein modified food products, administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. Examples of conditions include:

- Metabolic diseases such as phenylketonuria (PKU) and maple syrup urine disease.
- Severe food allergies.
- Impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract.

Benefits for prescription or over-the-counter formula are available when a Physician issues a prescription or written order stating the formula or product is Medically Necessary for the therapeutic treatment of a condition requiring specialized nutrients and specifying the quantity and the duration of the prescription or order. The formula or product must be administered under the direction of a Physician or registered dietitian.

For the purpose of this Benefit, "enteral formulas" include:

- Amino acid-based elemental formulas.
- Extensively hydrolyzed protein formulas.
- Modified nutrient content formulas.

For the purpose of this Benefit, "severe food allergies" mean allergies which if left untreated will result in:

- Malnourishment.
- Chronic physical disability.
- Intellectual disability; or
- Loss of life.

**Hearing Aids**

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

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

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.
Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every 3 calendar years.

**Home Health Care**

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

- Ordered by a Physician.
- Provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Not considered Custodial Care, as defined in Section 14, Glossary.
- Provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 14, Glossary for the definition of Skilled Care.

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

Benefits are limited to 6 home or office Physicians visits per month, 3 nursing visits per week and 20 hours of home health aide visits per week. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

**Hospice Care**

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

**Hospital - Inpatient Stay**

Hospital Benefits are available for:

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

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

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

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

**Infertility Services**

Therapeutic services for the treatment of infertility when provided by or under the direction of a Physician. The Plan pays Benefits for infertility when provided by a Designated Provider participating in the Fertility Solutions (FS) program. Designated Provider is defined in Section 14, Glossary.

*Note.* Diagnostic services Benefits are covered as described under Physician’s Office Services - Sickness and Injury in this section.

Benefits under this section are limited to the following procedures:

- Ovulation induction and controlled ovarian stimulation.
- Insemination procedures: Artificial Insemination (AI) and Intrauterine Insemination (IUI).
- Assisted Reproductive Technologies (ART): in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), Intra Cytoplasmic Sperm Injection (ICSI).
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm.
- Cryopreservation - embryo’s (storage is limited to 12 months).

*Note.* Long-term storage costs (anything longer than 12 months) are not covered under the Plan.

- Pre-implantation Genetic Diagnosis (PGD) for diagnosis of genetic disorders only.
- Embryo transportation related network disruption.
- Donor coverage - associated donor medical expenses, including collection and preparation of oocyte (egg) and/or sperm, and the medications associated with the collection and preparation of oocyte and/or sperm.

*Note.* The Plan does not cover donor charges associated with compensation or administrative services.
Fertility Preservation - when planned cancer or other medical treatment is likely to produce infertility/sterility, the plan covers the collection of sperm, cryopreservation of sperm, ovulation induction and retrieval of oocyte (egg), oocyte cryopreservation, in vitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.

To be eligible for Benefits, the Covered Person must:

- Have failed to achieve a Pregnancy after a year of regular, unprotected intercourse if the woman is under age 35, or after six months, if the woman is over age 35.
- Have failed to achieve Pregnancy following twelve cycles (under age 35) or six cycles (age 35 or over) of donor insemination.
- Have failed to achieve Pregnancy due to impotence/sexual dysfunction.
- Have infertility that is not related to voluntary sterilization.
- Be under age 44, if female and using own oocytes (eggs).
- Be under age 50, if female and using donor oocytes (eggs).

*Note.* For treatment initiated prior to pertinent birthday, services will be covered to completion of initiated cycle.

- Have diagnosis of a male factor causing infertility (e.g. treatment of sperm abnormalities including the surgical recovery of sperm).
- Not a Child Dependent.

The waiting period may be waived when Covered Person has a known infertility factor, including but not limited to: congenital malformations, known male factor, known ovulatory disorders, diminished ovarian reserve, impotence/sexual dysfunction, moderate or severe endometriosis, or documented compromise of the fallopian tubes.

Benefits are limited to $100,000 per Covered Person during the entire period you are covered under the Plan. This is a combined medical and prescription drug lifetime maximum benefit.

You must obtain prior authorization from the Claims Administrator as soon as the possibility of the need for Infertility Services arises.

**Lab, X-Ray and Diagnostics - Outpatient**

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

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:
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- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other physician services are described under Physician Fees for Surgical and Medical Services.)
- Presumptive Drug Tests and Definitive Drug Tests.
  Benefits are limited to 18 Presumptive Drug Tests per calendar year.
  Benefits are limited to 18 Definitive Drug Tests per calendar year.

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

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

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

Benefits under this section include:

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

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

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.
- Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).
Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

**Neurobiological Disorders - Autism Spectrum Disorder Services**

The Plan pays Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Provided by a Board Certified Applied Behavior Analyst (BCBA) or other qualified provider under the appropriate supervision.
- 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 behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient Treatment.
- Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).
- Services include the following:
- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.
- Provider-based case management services.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

**Obesity Surgery**

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician provided either of the following is true:

- You have a minimum Body Mass Index (BMI) of 40.
- You have a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by obesity.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 14, Glossary and are not Experimental or Investigational or Unproven Services.

**Ostomy Supplies**

Benefits for ostomy supplies are limited to:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

**Pharmaceutical Products - Outpatient**

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

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or
directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this SPD. Benefits for medication normally available by prescription or order or refill are provided as described under your Outpatient Prescription Drug Plan. Benefits under this section do not include medications for the treatment of infertility.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, UnitedHealthcare may direct you to a designated dispensing entity with whom UnitedHealthcare has an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a designated dispensing entity and you/your provider choose not to obtain your Pharmaceutical Product from a designated dispensing entity, Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting UnitedHealthcare at www.myuhc.com or by calling the telephone number on your ID card.

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

**Physician Fees for Surgical and Medical Services**

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

**Physician's Office Services - Sickness and Injury**

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

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

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

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

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

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

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

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

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

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

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

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

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, Clinical Programs and Resources, for details.

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

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

Preventive care Benefits defined under the **Health Resources and Services Administration (HRSA)** requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on how to access Benefits for breast pumps by going to www.myuhc.com or by calling the number on your ID card. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 5, **Plan Highlights**, under **Covered Health Services**.

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

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

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

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

**Prosthetic Devices**

Benefits are paid by the Plan for external prosthetic devices that replace a limb or body part limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, 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.

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

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

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

Benefits are limited to a single purchase of each type of prosthetic device every three calendar years.

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

**Reconstructive Procedures**

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

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

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

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures
that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedures. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, Glossary.

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

**Rehabilitation Services - Outpatient Therapy and Manipulative Treatment**

The Plan provides short-term outpatient rehabilitation services (including habilitative services) limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy following a post-traumatic brain Injury or stroke.
- Pulmonary rehabilitation.
- Cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician’s office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person’s home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in a Covered Person’s home other than by a Home Health Agency are provided as described under this section.

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

For outpatient rehabilitation services for speech therapy, the Plan will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly. The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or stroke.
**Habilitative Services**

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is ordered by a Physician and provided and administered by a licensed provider.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

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

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and Residential Treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

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

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment and Prosthetic Devices.*
Benefits are limited to:

- 20 visits per calendar year for physical therapy.
- 20 visits per calendar year for occupational therapy.
- 20 visits per calendar year for speech therapy.
- 20 visits per calendar year for pulmonary rehabilitation therapy.
- 36 visits per calendar year for cardiac rehabilitation therapy.
- 20 visits per calendar year for cognitive rehabilitation therapy.
- 20 visits per calendar year for Manipulative Treatment.
- 30 visits per calendar year for post-cochlear implant aural therapy.

**Scopic Procedures - Outpatient Diagnostic and Therapeutic**

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

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

Benefits under this section include:

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

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

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

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

**Skilled Nursing Facility/Inpatient Rehabilitation Facility Services**

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

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists.
Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

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

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

Benefits are available only if both of the following are true:

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

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 dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

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

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 14, Glossary.

Benefits are limited to 60 days per calendar year.

Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider’s office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:
Inpatient treatment.
Residential Treatment.
Partial Hospitalization/Day Treatment.
Intensive Outpatient Treatment.
Outpatient treatment.
Inpatient treatment and Residential Treatment includes room and board in a Semi- private Room (a room with two or more beds).

Services include the following:
- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Crisis intervention.
- Provider-based case management services.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

**Surgery - Outpatient**

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

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Examples of surgical procedures performed in a Physician’s office are mole removal and ear wax removal.

Benefits under this section include:
- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*
**Temporomandibular Joint (TMJ) Services**

The Plan covers services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

**Diagnosis:** Examination, radiographs and applicable imaging studies and consultation.

Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations.

Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under *Hospital - Inpatient Stay and Physician Fees for Surgical and Medical Services*, respectively.

**Therapeutic Treatments - Outpatient**

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

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

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

Benefits under this section include:

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

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SECTION 6 - ADDITIONAL COVERAGE DETAILS
Transplantation Services

Organ and tissue transplants including CAR-T cell therapy for malignancies when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow including CAR-T cell therapy for malignancies, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient’s coverage under the Plan.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures must be received by a Designated Provider.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from the Claims Administrator for a cornea transplant nor is the cornea transplant required to be performed by a Designated Provider.

Support in the event of serious illness

If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, Glossary. When Urgent Care services are provided in a Physician’s office, the Plan pays Benefits as described under Physician’s Office Services - Sickness and Injury.

Virtual Visits

Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through live audio with video technology or audio only. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio with video communications or audio only equipment outside of a medical facility (for example, from home or from work).
Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling the telephone number on your ID card.

**Please Note:** Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary.

Benefits under this section do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (CMS defined originating facilities).

**Vision Examinations**

The Plan pays Benefits for one routine vision exam, including refraction, to detect vision impairment by a provider in the provider’s office or outpatient facility every other calendar year.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury*.

**Wigs**

The Plan pays Benefits for wigs and other scalp hair prosthesis regardless of the reason of hair loss.
SECTION 7 - CLINICAL PROGRAMS AND RESOURCES

What this section includes:
Health and well-being resources available to you, including:
■ Consumer Solutions and Self-Service Tools.
■ Disease Management Services.
■ Complex Medical Conditions Programs and Services.
■ Wellness Programs.
■ Women’s Health/Reproductive.

Children’s Friend believes in giving you tools to help you be an educated health care consumer. To that end, Children’s Friend has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

■ Take care of yourself and your family members.
■ Manage a chronic health condition.
■ Navigate the complexities of the health care system.

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

Consumer Solutions and Self-Service Tools

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

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way.

If you need any assistance with the online survey, please call the number on your ID card.
**Reminder Programs**

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

- Mammograms for women.
- Pediatric and adolescent immunizations.
- Cervical cancer screenings for women.
- Comprehensive screenings for individuals with diabetes.
- Influenza/pneumonia immunizations for enrollees.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

**Decision Support**

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- Access to health care information.
- Support by a nurse to help you make more informed decisions in your treatment and care.
- Expectations of treatment.
- Information on providers and programs.

Conditions for which this program is available include:

- Back pain.
- Knee & hip replacement.
- Prostate disease.
- Prostate cancer.
- Benign uterine conditions.
- Breast cancer.
- Coronary disease.
- Bariatric surgery.

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

The Plan offers a second opinion service.

UnitedHealth Premium® Designation Program

To help people make more informed choices about their health care, the UnitedHealth Premium® designation program recognizes Network Physicians who meet criteria for quality and cost efficiency. UnitedHealthcare uses national standardized measures to evaluate quality. The cost efficiency criteria rely on local market benchmarks for the efficient use of resources in providing care.

For details on the UnitedHealth Premium® designation program including how to locate a Premium Care Physician, log onto www.myuhc.com or call the number on your ID card.

www.myuhc.com

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

With www.myuhc.com you can:

- Research a health condition and treatment options to get ready for a discussion with your Physician.
- Search for Network providers available in your Plan through the online provider directory.
- Complete a health survey to help you identify health habits you may improve, learn about healthy lifestyle techniques and access health improvement resources.
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area.
- Use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com

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

Visit www.myuhc.com and:

- Make real-time inquiries into the status and history of your claims.
- View eligibility and Plan Benefit information, including Copays and Annual Deductibles.
- View and print all of your Explanation of Benefits (EOBs) online.
- Order a new or replacement ID card or print a temporary ID card.
Want to learn more about a condition or treatment?
Log on to www.myuhc.com and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease Management Services

Disease Management Services
If you have been diagnosed with certain chronic medical conditions you may be eligible to participate in a disease management program at no additional cost to you. The heart failure, coronary artery disease, diabetes, asthma and Chronic Obstructive Pulmonary Disease (COPD) programs are designed to support you. This means that you will receive free educational information and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- Educational materials that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications.
- Access to educational and self-management resources on a consumer website.
- An opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care.
- Access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
  - Education about the specific disease and condition.
  - Medication management and compliance.
  - Reinforcement of on-line behavior modification program goals.
  - Preparation and support for upcoming Physician visits.
  - Review of psychosocial services and community resources.
  - Caregiver status and in-home safety.
  - Use of mail-order pharmacy and Network providers.

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

Complex Medical Conditions Programs and Services

Cancer Resource Services (CRS) Program
Your Plan offers Cancer Resource Services (CRS) program to provide you with access to information and member assistance through a team of specialized cancer nurse consultants and access to one of the nation’s leading cancer programs.

To learn more about CRS, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card or call the program directly at 1-866-936-6002.
Coverage for oncology services and oncology-related services are based on your health plan’s terms, exclusions, limitations and conditions, including the plan’s eligibility requirements and coverage guidelines. Participation in this program is voluntary.

**Comprehensive Kidney Solution (CKS) program**

For participants diagnosed with Kidney Disease, your Plan offers the Comprehensive Kidney Solution (CKS) program to help you manage the effects of advanced Chronic Kidney Disease (CKD) through End-stage Renal Disease (ESRD).

Should the disease progress to the point of needing dialysis, CKS provides access to top-performing dialysis centers. That means you will receive treatment based on a “best practices” approach from health care professionals with demonstrated expertise.

There are hundreds of contracted dialysis centers across the country, but in situations where you cannot conveniently access a contracted dialysis center, CKS will work to negotiate patient-specific agreements on your behalf.

To learn more about Comprehensive Kidney Solutions, visit [www.myoptumhealthcomplexmedical.com](http://www.myoptumhealthcomplexmedical.com) or call the number on your ID card.

Coverage for dialysis and kidney-related services are based on your health plan’s terms, exclusions, limitations and conditions, including the plan’s eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you decide to no longer participate in the program, please contact CKS of your decision.

**Kidney Resource Services (KRS) program**

**End-Stage Renal Disease (ESRD)**

The Kidney Resource Services program provides Covered Persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS program, you’ll work with a nurse who will provide you with support and information. The nurse can help you manage other conditions, such as diabetes and high blood pressure. He or she can also help you find doctors, specialists and dialysis centers. This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have been referred to the KRS program by your medical provider or from past claim information. As part of your health insurance benefits, it’s available at no extra cost to you.

KRS nurse advocates are available, Monday through Friday toll-free at 1-866-561-7518 (TTY: 711).

Coverage for dialysis and kidney-related services are based on your health plan’s terms, exclusions, limitations and conditions, including the plan’s eligibility requirements and coverage guidelines. Participation in this program is voluntary.
**Congenital Heart Disease (CHD) Resource Services**

UnitedHealthcare provides a program that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with you and your Physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit [www.myoptumhealthcomplexmedical.com](http://www.myoptumhealthcomplexmedical.com) or call UnitedHealthcare at the number on your ID card or you can call the CHD Resource Services Nurse Team at 888-936-7246.

Coverage for CHD surgeries and related services are based on your health plan’s terms, exclusions, limitations and conditions, including the plan’s eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD surgeries you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be considered a Covered Health Service under the Plan.

**Orthopedic Health Support Program**

Orthopedic Health Support is a program that provides you access to specialized nurses and high-performing providers to help meet your specific needs from early pain onset through treatment and beyond.

This program offers:

- Early intervention and appropriate care.
- Coaching to support behavior change.
- Shared decision-making.
- Pre- and post-surgical counseling.
- Support in choosing treatment options.
- Education on back-related information and self-care strategies.
- Long-term support.

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

If you are considering surgery you must contact an Orthopedic nurse prior to surgery to enroll in the program in order for the surgery to be considered a Covered Health Service under the Plan.

**Transplant Resource Services (TRS) Program**

Your Plan offers Transplant Resource Services (TRS) program to provide you with access to one of the nation’s leading transplant programs. Receiving transplant services through this
program means your transplant treatment is based on a “best practices” approach from health care professionals with extensive expertise in transplantation.

To learn more about Transplant Resource Services, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card.

Coverage for transplant and transplant-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan’s eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Wellness Programs

*Quit For Life Program*

UnitedHealthcare provides a tobacco cessation program to help tobacco users withdraw from nicotine dependence. The Quit For Life® program employs an evidence-based combination of physical, psychological and behavioral strategies to help enable you to take responsibility for and overcome your addiction to tobacco use.

If you are a tobacco user, the Quit For Life® program tailors a quitting plan for you and incorporates the following components:

- Multiple planned phone-based coaching sessions.
- Unlimited access to Quit Coach® staff for ongoing support for the duration of your program via toll-free phone and live chat.
- Nicotine replacement therapy (patch or gum) sent to you in conjunction with your quit date.
- Unlimited access to a mobile-friendly online web portal, including support tools that complement your phone-based coaching.
- An online Quit Guide designed to complement your phone-based coaching sessions and web activity.
- Tailored motivational emails sent throughout your quitting process.
- Personalized, interactive text messages.

If you would like to enroll in Quit For Life®, or if you would like additional information regarding the program and also how to access the program online, please call the number on your ID card.

*Women’s Health/Reproductive*

*Maturity Support Program*

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get valuable educational information, advice and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:
- Enrollment by an OB nurse.
- Pre-conception health coaching.
- Written and online educational resources covering a wide range of topics.
- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.
- Coordination with and referrals to other benefits and programs available under the medical plan.
- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
- Post-partum depression screening.

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

As a program participant, you can always call your nurse with any questions or concerns you might have.

**Neonatal Resource Services (NRS)**

NRS is a program administered by the Claims Administrator or its affiliates made available to you by the Plan Sponsor. NRS provides a dedicated team of experienced Neonatologists, Neonatal Intensive Care Unit (NICU) nurse case managers and social workers who can provide support and assistance to you and your family during your infant’s admission to the NICU. The case manager will also provide discharge planning assistance and ongoing support post-discharge based on your infant’s needs.

To take part in the NRS program you or a covered Dependent can call the Claims Administrator at the telephone number on your ID card or call NRS directly at 1-866-534-7209.

**Fertility Solutions**

Fertility Solutions is a program administered by UnitedHealthcare or its affiliates made available to you by the Plan Sponsor. The Infertility Solutions program provides:

- Specialized clinical consulting services to Participants and Enrolled Dependents to educate on infertility treatment options.
- Access to specialized Network facilities and Physicians for infertility services.

The Plan pays Benefits for the infertility services described above when provided by Designated Providers participating in the Fertility Solutions program. The Fertility Solutions provides education, counseling, infertility management and access to a national Network of premier infertility treatment clinics.
Covered Persons who do not live within a 60 mile radius of a Fertility Solutions Designated Provider will need to contact a Fertility Solutions case manager to determine a Network Provider prior to starting treatment. For infertility services and supplies to be considered Covered Health Services through this program, contact Fertility Solutions and enroll with a nurse consultant prior to receiving services.

You or a covered Dependent may:

■ Be referred to Fertility Solutions by the Claims Administrator.
■ Call the telephone number on your ID card.
■ Call Fertility Solutions directly at 1-866-774-4626.

To take part in the Fertility Solutions program, call a nurse at 1-866-774-4626. The Plan will only pay Benefits under the Fertility Solutions program if Fertility Solutions provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).
SECTION 8 - EXCLUSIONS AND LIMITATIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:
- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, Additional Coverage Details.

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

When Benefits are limited within any of the Covered Health Services categories described in Section 6, Additional Coverage Details, those limits are stated in the corresponding Covered Health Service category in Section 5, Plan Highlights. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, Plan Highlights. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

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

Alternative Treatments
1. Acupressure.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, Additional Coverage Details.

Dental
1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).
This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 6, Additional Coverage Details.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

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

- Extractions (including wisdom teeth), restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement or the Health Resources and Services Administration (HRSA) requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 6, Additional Coverage Details.

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

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only in Section 6, Additional Coverage Details.

4. Dental braces (orthodontics).

5. Treatment of congenitally missing, malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly.

**Devices, Appliances and Prosthetics**

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

2. Orthotic appliances and devices that straighten or re-shape a body part, except as described under Durable Medical Equipment (DME) in Section 6, Additional Coverage Details.
Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics and some types of braces, including orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.

3. Cranial molding helmets and cranial banding except when used to avoid the need for surgery, and/or to facilitate a successful surgical outcome.

4. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.

5. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.

6. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

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


**Drugs**

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See Section 15, Outpatient Prescription Drugs, for coverage details and exclusions.

1. Prescription Drug Products for outpatient use that are filled by a prescription order or refill.

2. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion.

3. Non-injectable medications given in a Physician’s office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician’s office.
4. Over-the-counter drugs and treatments.

5. Growth hormone therapy.

6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator’s designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 6, Additional Coverage Details.

7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

9. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

10. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

11. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

12. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

**Experimental or Investigational or Unproven Services**

1. Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or 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 or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under Clinical Trials in Section 6, Additional Coverage Details.

Foot Care
1. Routine foot care. Examples include the cutting or removal of corns and calluses.
   This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in Section 6, Additional Coverage Details.
2. Nail trimming, cutting, or debriding (removal of dead skin or underlying tissue).
3. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.
   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
7. Shoe orthotics.
8. Shoe inserts.

Medical Supplies
1. Prescribed or non-prescribed medical and disposable supplies. Examples include:
   - Compression stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.

   This exclusion does not apply to:
   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in Section 6, Additional Coverage Details.
- Diabetic supplies for which Benefits are provided as described under Diabetes Services in Section 6, Additional Coverage Details.
- Ostomy supplies for which Benefits are provided as described under Ostomy Supplies in Section 6, Additional Coverage Details.

2. Tubings and masks except when used with Durable Medical Equipment as described under Durable Medical Equipment in Section 6, Additional Coverage Details.

### Mental Health, Neurobiological Disorders - Autism Spectrum Disorder Services and Substance-Related and Addictive Disorders Services

In addition to all other exclusions listed in this Section 8, Exclusions and Limitations, the exclusions listed directly below apply to services described under Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services and/or Substance-Related and Addictive Disorders Services in Section 6, Additional Coverage Details.

1. Services performed in connection with conditions not classified in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association.

2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder, and paraphilic disorders.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the Individuals with Disabilities Education Act.

6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

7. Transitional Living services.


9. High intensity residential care including American Society of Addiction Medicine (ASAM) criteria for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.
Nutrition

1. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

2. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement. This exclusion also does not apply to nutritional counseling services that are billed as Preventive Care Services or to nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

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

3. Food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to enteral formula and other modified food products for which Benefits are provided as described under Enteral Nutrition in Section 6, Additional Coverage Details.

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

Personal Care, Comfort or Convenience

1. Television.

2. Telephone.


4. Guest service.

5. Supplies, equipment and similar incidentals for personal comfort. Examples include:
   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps. (This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement.)
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, ergonomically correct chairs, chair lifts and recliners.
   - Exercise equipment and treadmills.
   - Hot and cold compresses.
- Hot tubs.
- Humidifiers.
- Jacuzzis.
- Medical alert systems.
- Motorized beds, non-Hospital beds, comfort beds and mattresses.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Safety equipment.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 14, Glossary. Examples include:
   - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Sclerotherapy treatment of veins.
   - Hair removal or replacement by any means.
   - Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
   - Treatment for spider veins.
   - Skin abrasion procedures performed as a treatment for acne.
   - Treatments for hair loss.
   - Varicose vein treatment of the lower extremities, when it is considered cosmetic.

2. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See Reconstructive Procedures in Section 6, Additional Coverage Details.

3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation.

4. Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity.

5. Treatment of benign gynecomastia (abnormal breast enlargement in males).
Procedures and Treatments

1. Biofeedback.

2. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

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

4. Outpatient cognitive rehabilitation therapy except as Medically Necessary following traumatic brain injury or stroke.

5. Speech therapy to treat stuttering, stammering, or other articulation disorders.

6. Rehabilitation services for speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorder as identified under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment in Section 6, Additional Coverage Details.

7. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.

8. Psychosurgery (lobotomy).

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

10. Chelation therapy, except to treat heavy metal poisoning.

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

12. Sex transformation operations and related services.

13. The following treatments for obesity:
   - Non-surgical treatment of obesity, even if for morbid obesity.
   - Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under Obesity Surgery in Section 6, Additional Coverage Details.

14. Medical and surgical treatment of excessive sweating (hyperhidrosis).
15. The following services for the diagnosis and treatment of temporomandibular joint syndrome (TMJ): surface electromyography, Doppler analysis, vibration analysis, computerized mandibular scan or jaw tracking, craniosacral therapy, orthodontics, occlusal adjustment, and dental restorations.

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

17. Breast reduction surgery that is determined to be a Cosmetic Procedure.

   This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women’s Health and Cancer Rights Act of 1998 for which Benefits are described under Reconstructive Procedures in Section 6, Additional Coverage Details.

18. Congenital Heart Disease surgery that is not received by a Designated Provider.


20. Intracellular micronutrient testing.

Providers
1. Services performed by a provider who is a family member by birth or marriage, including your 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 ordered or delivered by a Christian Science practitioner.

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

5. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:

   - Has not been actively involved in your medical care prior to ordering the service.
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.

Reproduction
1. The following treatment-related services:
- Cryo-preservation and other forms of preservation of reproductive materials except as described under Infertility Services.
- Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
- Donor services and non-medical costs of oocyte or sperm donation such as donor agency fees.
- Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes.
- Natural cycle insemination in the absence of sexual dysfunction or documented congenital or acquired cervical disease or mild to moderate male factor.
- Ovulation predictor kits.

2. The following services related to Gestational Carrier or Surrogate:
   - Fees for the use of a Gestational Carrier or Surrogate.
   - Insemination costs of Surrogate or transfer embryo to Gestational Carrier, except as provided in Infertility Services under the heading Additional Benefit Coverage for Reciprocal IVF or Partner IVF.
   - IVF for a traditional Surrogate.
   - Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.

3. Cost of donor eggs and donor sperm.

4. The reversal of voluntary sterilization.

5. In vitro fertilization that is not an Assisted Reproductive Technology for the treatment of Infertility.

6. Artificial reproductive treatments done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.

7. Infertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation)

8. Infertility treatment following unsuccessful reversal of voluntary sterilization.

9. Infertility Treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis; vasectomy reversal/vasovasostomy or vasoepididymostomy).

**Services Provided under Another Plan**

Services for which coverage is available:

1. Under another plan, except for Eligible Expenses payable as described in Section 10, Coordination of Benefits (COB).

2. Under workers' compensation, or similar legislation if you could elect it, or could have it elected for you.
3. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

4. While on active military duty.

5. For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably available to you.

**Transplants**

1. Health services for organ and tissue transplants except those described under Transplantation Services in Section 6, Additional Coverage Details unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.

2. Health services for transplants involving animal organs.

3. Transplants that are not performed by a Designated Provider. (This exclusion does not apply to cornea transplants.)

4. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Plan.)

**Travel**

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

2. Travel or transportation expenses. Additional travel expenses related to Covered Health Services received from a Designated Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in Section 6, Additional Coverage Details.

**Types of Care**

1. Custodial Care or maintenance care as defined in Section 14, Glossary or maintenance care.

2. Domiciliary Care, as defined in Section 14, Glossary.

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

4. Private Duty Nursing.

5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice
care agency for which Benefits are provided as described under Hospice Care in Section 6, Additional Coverage Details.

6. Rest cures.

7. Services of personal care attendants.

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

**Vision and Hearing**

1. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants).

2. Purchase cost and associated fitting charges for eyeglasses or contact lenses.

3. 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.

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

4. Eye exercise or vision therapy.

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

**All Other Exclusions**

1. Autopsies and other coroner services and transportation services for a corpse.

2. Charges for:
   - Missed appointments.
   - Room or facility reservations.
   - Completion of claim forms.
   - Record processing.

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

4. Diagnostic tests that are:
- Delivered in other than a Physician’s office or health care facility.
- Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests.

5. Expenses for health services and supplies:
- That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
- That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends.
- For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan.
- That exceed Eligible Expenses or any specified limitation in this SPD.

6. In the event a provider waives, does not pursue, or fails to collect the Copayment, Coinsurance, any deductible or other amount owed for a particular health service, no Benefits are provided for the health service for which the Copayment, Coinsurance and/or deductible are waived.

7. Foreign language and sign language services.

8. Long term (more than 30 days) storage of blood, umbilical cord or other material.

9. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 14, Glossary. Covered Health Services are those health services including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:
- Medically Necessary.
- Described as a Covered Health Service in this SPD under Section 6, Additional Coverage Details and in Section 5, Plan Highlights.
- Not otherwise excluded in this SPD under this Section 8, Exclusions and Limitations.

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

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

11. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments when:
- Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration.
- Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under Clinical Trials in Section 6, Additional Coverage Details.
- Related to judicial or administrative proceedings or orders.
- Required to obtain or maintain a license of any type.
SECTION 9 - CLAIMS PROCEDURES

What this section includes:
■ How Network and non-Network claims work.
■ What to do if your claim is denied, in whole or in part.

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

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

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

Prescription Drug Benefit Claims
If you wish to receive reimbursement for a prescription, you may submit a post-service claim as described in this section if:
■ You are asked to pay the full cost of the Prescription Drug Product when you fill it and you believe that the Plan should have paid for it.
■ You pay a Copay and you believe that the amount of the Copay was incorrect.

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

If Your Provider Does Not File Your Claim
You can obtain a claim form by visiting www.myuhc.com, calling the toll-free number on your ID card or contacting Human Resources. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:
■ Your name and address.
■ The patient’s name, age and relationship to the Participant.
- The number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
  - A description of, and the charge for, each service.
  - The date the Sickness or Injury began.
  - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

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

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card. When filing a claim for Outpatient Prescription Drug Product Benefits, your claims should be submitted to:

Optum RX
PO Box 29077
Hot Springs, AR 71903

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

Payment of Benefits
When you assign your Benefits under the Plan to a non-Network provider with UnitedHealthcare’s consent, and the provider submits a claim for payment, you and the provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person’s agreement that the non-Network provider will be entitled to all the Covered Person’s rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person’s Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form does not comply with this requirement, but directs that your benefit payment should be made directly to the provider, UnitedHealthcare may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If Benefits are assigned or payment to a provider is made, Children's Friend reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes Children's Friend (including amounts owed as a result of the assignment of other plans’ overpayment recovery rights to the Plan) pursuant to Refund of Overpayments in Section 10, Coordination of Benefits.
UnitedHealthcare will pay Benefits to you unless:

- The provider submits a claim form to UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider.
- You make a written request for the provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

**Form of Payment of Benefits**

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans’ recovery rights for value.

**Health Statements**

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family’s medical costs by providing claims information in easy-to-understand terms.

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

**Explanation of Benefits (EOB)**

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBS, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBS online at [www.myuhc.com](http://www.myuhc.com). See Section 14, *Glossary*, for the definition of Explanation of Benefits.
Important - Timely Filing of Non-Network Claims
All claim forms for non-Network services must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

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

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

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

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

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

For urgent care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.
Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent care request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim.

Urgent 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. If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your health plan ID card. Generally, an urgent situation is when your life or health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your claim or appeal.

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

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

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

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

Note: Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.
Federal External Review Program

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

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

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the 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 UnitedHealthcare's decision.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- 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.
- An expedited external review.

**Standard External Review**

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

- A preliminary review by UnitedHealthcare of the request.
- A referral of the request by UnitedHealthcare to the IRO.
- 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.
■ 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 UnitedHealthcare’s determination. The documents include:

■ All relevant medical records.
■ All other documents relied upon by UnitedHealthcare.
■ 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 as new and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

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

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

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

■ An adverse benefit determination of a claim or appeal if the adverse benefit
determination involves a medical condition for which the time frame for completion of
an expedited internal appeal would seriously jeopardize the life or health of the
individual or would jeopardize the individual’s ability to regain maximum function and
you have filed a request for an expedited internal appeal.

■ A final appeal decision, if the determination involves a medical condition where the
timeframe for completion of a standard external review would seriously jeopardize the
life or health of the individual or would jeopardize the individual’s ability to regain
maximum function, or if the final appeal decision concerns an admission, availability of
care, continued stay, or health care service, procedure or product for which the
individual received emergency services, but has not been discharged from a facility.

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

■ Is or was covered under the Plan at the time the health care service or procedure that is
at issue in the request was provided.

■ Has provided all the information and forms required so that UnitedHealthcare may
process the request.

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

In reaching a decision, the IRO will review the claim as new and not be bound by any
decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the
final external review decision for an expedited external review as expeditiously as the
claimant’s medical condition or circumstances require, but in no event more than 72 hours
after the IRO receives the request. If the initial notice is not in writing, within 48 hours after
the date of providing the initial notice, the assigned IRO will provide written confirmation of
the decision to you and to UnitedHealthcare.
You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

**Timing of Appeals Determinations**

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

- **Urgent care request for Benefits** - a request for Benefits provided in connection with urgent care services.
- **Pre-Service request for Benefits** - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-urgent care is provided.
- **Post-Service** - a claim for reimbursement of the cost of non-urgent care that has already been provided.

Please note that the decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

You may have the right to external review through an **Independent Review Organization (IRO)** upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator's decision letter to you.

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

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

<table>
<thead>
<tr>
<th>Type of Request for Benefits or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>You do not need to submit urgent care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an urgent care request for Benefits.</td>
<td></td>
</tr>
</tbody>
</table>

### Pre-Service Request for Benefits

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

*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.*
### Post-Service Claims

<table>
<thead>
<tr>
<th>Type of Claim or Appeal</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your claim is incomplete, UnitedHealthcare must notify you within:</td>
<td>30 days</td>
</tr>
<tr>
<td>You must then provide completed claim information to UnitedHealthcare within:</td>
<td>45 days</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the benefit determination:</td>
<td></td>
</tr>
<tr>
<td>■ if the initial claim is complete, within:</td>
<td>30 days</td>
</tr>
<tr>
<td>■ after receiving the completed claim (if the initial claim is incomplete), within:</td>
<td>30 days</td>
</tr>
<tr>
<td>You must appeal an adverse benefit determination no later than:</td>
<td>180 days after receiving the adverse benefit determination</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the first level appeal decision within:</td>
<td>30 days after receiving the first level appeal</td>
</tr>
<tr>
<td>You must appeal the first level appeal (file a second level appeal) within:</td>
<td>60 days after receiving the first level appeal decision</td>
</tr>
<tr>
<td>UnitedHealthcare must notify you of the second level appeal decision within:</td>
<td>30 days after receiving the second level appeal</td>
</tr>
</tbody>
</table>

### Concurrent Care Claims

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

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

### Limitation of Action

You cannot bring any legal action against Children's Friend or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for
reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against Children's Friend 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 Children's Friend or the Claims Administrator.

You cannot bring any legal action against Children's Friend or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against Children's Friend or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against Children's Friend or the Claims Administrator.
SECTION 10 - COORDINATION OF BENEFITS (COB)

What this section includes:
■ How your Benefits under this Plan coordinate with other medical plans.
■ How coverage is affected if you become eligible for Medicare.
■ Procedures in the event the Plan overpays Benefits.

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

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

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, "allowable expense," is further explained below.

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

Determining Which Plan is Primary
Order of Benefit Determination Rules
If you are covered by two or more plans, the benefit payment follows the rules below in this order:

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

Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
- The parents are married or living together whether or not they have ever been married and not legally separated.
- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
- The parent with custody of the child; then
- The Spouse of the parent with custody of the child; then
- The parent not having custody of the child; then
- The Spouse of the parent not having custody of the child.

Plans for active employees pay before plans covering laid-off or retired employees.

The plan that has covered the individual claimant the longest will pay first.

Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

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

**Determining Primary and Secondary Plan - Examples**

1) Let’s say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you’re covered as a Participant under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.

2) Again, let’s say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

**When This Plan is Secondary**

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.
The Plan determines the amount it would have paid based on the allowable expense. The Plan pays the entire difference between the allowable expense and the amount paid by the primary plan - as long as this amount is not more than the Plan would have paid had it been the only plan involved.

You will be responsible for any Copay, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the allowable expense.

**Determining the Allowable Expense If This Plan is Secondary**

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

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When This Plan is Secondary to Medicare".

**When a Covered Person Qualifies for Medicare**

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

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

**Determining the Allowable Expense When This Plan is Secondary to Medicare**
If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.
If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don’t accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program (as opposed to a provider who does not accept assignment of Medicare benefits), Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan’s Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience UnitedHealthcare will treat the provider's billed charges for covered services as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

**Medicare Crossover Program**

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated Crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses under Part A of Medicare (hospital expenses) and to expenses under Part B (Physician office visits) and DME Medicare expenses or expenses that Medicare does not cover. You must go on to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on your ID card.

**Right to Receive and Release Needed Information**

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.
UnitedHealthcare does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

**Overpayment and Underpayment of Benefits**

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

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

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

**Refund of Overpayments**

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

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

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

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payable in connection with services provided to persons under other plans for which UnitedHealthcare makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required
refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.
SECTION 11 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

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

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

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

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

The following persons and entities are considered third parties:

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

Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

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

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

- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan’s first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan’s subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys’ fees, shall be deducted from the Plan’s recovery without the Plan’s express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney’s Fund Doctrine" shall defeat this right.
Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan’s subrogation and reimbursement rights.

Benefits paid by the Plan may also be considered to be Benefits advanced.

If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative’s trust account.

By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.

The Plan's rights to recovery will not be reduced due to your own negligence.

By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.

The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate’s name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.

You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.

In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the participant, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery
The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.
Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

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

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

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

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.
SECTION 12 - WHEN COVERAGE ENDS

What this section includes:

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

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

When your coverage ends, Children’s Friend will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

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

- The last day of the month your employment with the Company ends.
- The date the Plan ends.
- The last day of the month you stop making the required contributions.
- The last day of the month you are no longer eligible.
- The last day of the month UnitedHealthcare receives written notice from Children’s Friend to end your coverage, or the date requested in the notice, if later.
- The last day of the month you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

Coverage for your eligible Dependents will end on the earliest of:

- The date your coverage ends.
- The last day of the month you stop making the required contributions.
- The last day of the month UnitedHealthcare receives written notice from Children’s Friend to end your coverage, or the date requested in the notice, if later.
- The last day of the month your Dependents no longer qualify as Dependents under this Plan.

Other Events Ending Your Coverage

The Plan will provide at least thirty days’ prior written notice to you that your coverage will end on the date identified in the notice if you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, knowingly providing incorrect information relating to another person’s eligibility or status as a Dependent. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.
Note: If UnitedHealthcare and Children's Friend find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact, Children's Friend has the right to demand that you pay back all Benefits Children's Friend paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

**Coverage for a Disabled Dependent Child**

Coverage for an unmarried enrolled Dependent child who is disabled will not end just because the child has reached a certain age. The Plan 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 or disability.
- Depends mainly on you for support.

Coverage will continue as long as the enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Plan.

The Plan will ask you to furnish proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before the Plan agrees to this extension of coverage for the child, the Plan may require that a Physician chosen by the Plan examine the child. The Plan will pay for that examination.

The Plan may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at the Plan's expense. However, the Plan will not ask for this information more than once a year.

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

**Continuing Coverage Through COBRA**

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, Glossary.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if Children's Friend is subject to the provisions of COBRA.

**Continuation Coverage under Federal Law (COBRA)**

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

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

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

- A Participant's former Spouse.

### Qualifying Events for Continuation Coverage under COBRA

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

<table>
<thead>
<tr>
<th>If Coverage Ends Because of the Following Qualifying Events:</th>
<th>You May Elect COBRA:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For Yourself</td>
</tr>
<tr>
<td>Your work hours are reduced</td>
<td>18 months</td>
</tr>
<tr>
<td>Your employment terminates for any reason (other than gross misconduct)</td>
<td>18 months</td>
</tr>
<tr>
<td>You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage¹</td>
<td>29 months</td>
</tr>
<tr>
<td>You die</td>
<td>N/A</td>
</tr>
<tr>
<td>You divorce (or legally separate)</td>
<td>N/A</td>
</tr>
<tr>
<td>Your child is no longer an eligible family member (e.g., reaches the maximum age limit)</td>
<td>N/A</td>
</tr>
<tr>
<td>You become entitled to Medicare</td>
<td>N/A</td>
</tr>
<tr>
<td>Children's Friend files for bankruptcy under Title 11, United States Code.²</td>
<td>36 months</td>
</tr>
</tbody>
</table>
1. Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

2. This is a qualifying event for any retired Participant and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

3. From the date of the Participant's death if the Participant dies during the continuation coverage.

**How Your Medicare Eligibility Affects Dependent COBRA Coverage**

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

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

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

**Getting Started**

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

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

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

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

■ During Open Enrollment.
■ Following a change in family status, as described under Changing Your Coverage in Section 2, Introduction.

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

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

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

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

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

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

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 16, Important Administrative Information: ERISA. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.
Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or ‘alternative trade adjustment assistance’ under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Participant must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Participant will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

When COBRA Ends

COBRA coverage will end before the maximum continuation period, on the earliest of the following dates:

- The date, after electing continuation coverage, that coverage is first obtained under any other group health plan.
- The date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare.
- The date coverage ends for failure to make the first required premium payment (premium is not paid within 45 days).
- The date coverage ends for failure to make any other monthly premium payment (premium is not paid within 30 days of its due date).
- The date the entire Plan ends.
- The date coverage would otherwise terminate under the Plan as described in the beginning of this section.

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

Uniformed Services Employment and Reemployment Rights Act

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

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

If qualified to continue coverage pursuant to the USERRA, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period of time less than 31 days, the Participant may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

A Participant may continue Plan coverage under USERRA for up to the lesser of:

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

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

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.
SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:
- Court-ordered Benefits for Dependent children.
- Your relationship with UnitedHealthcare and Children's Friend.
- Relationships with providers.
- Interpretation of Benefits.
- Information and records.
- Incentives to providers and you.
- The future of the Plan.
- How to access the official Plan documents.

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

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

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

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

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

- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive. The Plan pays for Covered Health Services, which are more fully described in this SPD.
- The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.
Children’s Friend and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. Children’s Friend and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. Children’s Friend and UnitedHealthcare will use de-identified data for commercial purposes including research.

**Relationship with Providers**

The Claims Administrator has agreements in place that govern the relationships between it and Children’s Friend and Network providers, some of which are affiliated providers. Network providers enter into agreements with the Claims Administrator to provide Covered Health Services to Covered Persons.

Children's Friend and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, Children's Friend and UnitedHealthcare arrange for health care providers to participate in a Network and administer payment of Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not Children's Friend's employees nor are they employees of UnitedHealthcare. Children’s Friend and UnitedHealthcare are not responsible for any act or omission of any provider.

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

Children’s Friend is solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the service fee to UnitedHealthcare.
- The funding of Benefits on a timely basis.
- Notifying you of the termination or modifications to the Plan.

When the Plan Sponsor establishes the Plan to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* (*ERISA*), 29 U.S.C. §1001 et seq., the Claims Administrator is not the plan administrator or named fiduciary of the benefit plan, as those terms are used in *ERISA*. If you have questions about your welfare benefit plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under *ERISA*, contact the nearest area office of the *Employee Benefits Security Administration*, U. S. Department of Labor.
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 are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- 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.
- 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 Children's Friend is that of employer and employee, Dependent or other classification as defined in the SPD.

Interpretation of Benefits
Children's Friend and UnitedHealthcare have the 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, the Schedule of Benefits and any Addendums, SMMs and/or Amendments.
- Make factual determinations related to the Plan and its Benefits.

Children's Friend and UnitedHealthcare may delegate this discretionary authority to other persons or entities including Claims Administrator's affiliates that may provide services in regard to the administration of the Plan. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

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

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies
UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, 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 sources or determinations that UnitedHealthcare accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to www.myuhc.com or by calling the telephone number on your ID card.

UnitedHealthcare may apply a reimbursement methodology established by OptumInsight and/or a third party vendor, which is based on CMS coding principles, to determine appropriate reimbursement levels for Emergency Health Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use a comparable methodology(ies). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable methodology.

**Information and Records**

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

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

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

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

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

In some cases, as permitted by law, Children’s Friend and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare’s designees have the same rights to this information as does the Plan Administrator.

**Incentives to Providers**

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

Examples of financial incentives for Network providers are:

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

- A practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person’s health care is less than or more than the payment.

- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. Your Copayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person’s health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Services that are not
considered part of the inclusive bundled payment and those Covered Health Services
would be subject to the applicable Copayment and/or Coinsurance as described in
Section 5, Plan Highlights.

If you have any questions regarding financial incentives you may contact the telephone
number on your ID card. You can ask whether your Network provider is paid 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. In addition, you may
choose to discuss these financial incentives with your Network provider.

Incentives to You
Sometimes you may be offered coupons, enhanced Benefits, or other incentives to
encourage you to participate in various wellness programs or certain disease management
programs, surveys, discount programs and/or programs to seek care in a more cost effective
setting and/or from Designated Providers. In some instances, these programs may be
offered in combination with a non-UnitedHealthcare entity. The decision about whether or
not to participate is yours alone but Children's Friend recommends that you discuss
participating in such programs with your Physician. These incentives are not Benefits and do
not alter or affect your Benefits. You may call the number on your ID card if you have any
questions. Additional information may be found in Section 7, Clinical Programs and Resources.

Rebates and Other Payments
Children's Friend and UnitedHealthcare may receive rebates for certain drugs that are
administered to you in a Physician’s office, or at a Hospital or Alternate Facility. This
includes rebates for those drugs that are administered to you before you meet your Annual
Deductible. Children’s Friend and UnitedHealthcare may pass a portion of these rebates on
to you. When rebates are passed on to you, they may be taken into account in determining
your Copays or Coinsurance.

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

Future of the Plan
Although the Company expects to continue the Plan indefinitely, it reserves the right to
discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at
its sole determination.

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

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

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

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

Medicare Eligibility
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.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don’t enroll and maintain that coverage, and if the Plan is the secondary payer as described in Section 10, Coordination of Benefits, the Plan will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare Advantage (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you should follow all rules of that plan that require you to seek services from that plan’s participating providers. When the Plan is the secondary payer, the Plan will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare Advantage plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.
SECTION 14 - GLOSSARY

What this section includes:

- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Addendum - any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

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

Annual Deductible (or Deductible) - the amount of Eligible Expenses you must pay for Covered Health Services in a calendar year before you are eligible to begin receiving Benefits in that calendar year. The Deductible is shown in the first table in Section 5, Plan Highlights.

Assisted Reproductive Technology (ART) - the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs, and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).
Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

BMI - see Body Mass Index (BMI).

Body Mass Index (BMI) - a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

Cancer Resource Services (CRS) - a program administered by UnitedHealthcare or its affiliates made available to you by Children's Friend. The CRS program provides:

- Specialized consulting services, on a limited basis, to Participants and enrolled Dependents with cancer.
- Access to cancer centers with expertise in treating the most rare or complex cancers.
- Education to help patients understand their cancer and make informed decisions about their care and course of treatment.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

CHD - see Congenital Heart Disease (CHD).

Claims Administrator - UnitedHealthcare (also known as United HealthCare) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial - a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA - see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services as described in Section 3, How the Plan Works and Section 15, Outpatient Prescription Drugs.

Company - Children's Friend.

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

Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited).
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy.
- Have no known cause.

**Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)** - a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

**Copayment (or Copay)** - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works* and Section 15, *Outpatient Prescription Drugs*.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

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

**Cost-Effective** - the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

**Covered Health Services** - those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Service in this SPD under Section 5, *Plan Highlights* and 6, *Additional Coverage Details* and Section 15, *Outpatient Prescription Drugs*.
- Provided to a Covered Person who meets the Plan’s eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*.
- Not otherwise excluded in this SPD under Section 8, *Exclusions and Limitations* or Section 15, *Outpatient Prescription Drugs*.

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

**CRS** - see Cancer Resource Services (CRS).

**Custodial Care** - services that are any of the following:
- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).

- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.

- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

**Deductible** - see Annual Deductible.

**Definitive Drug Test** - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

**Dependent** - an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as a Participant. No one can be a Dependent of more than one Participant.

**Designated Network Benefits** – for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for the Covered Health Services provided by a Physician or other provider that has been identified as a Designated Provider. Refer to Section 5, *Plan Highlights*, to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

**Designated Provider** - a provider and/or facility that:

- Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or

- The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting the Claims Administrator at [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card.

**Designated Virtual Network Provider** - a provider or facility that has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to deliver Covered Health Services via interactive audio and video modalities.

**DME** - see Durable Medical Equipment (DME).
Domestic Partner - a person of the same or opposite sex with whom the Participant has established a Domestic Partnership.

Domestic Partnership - a relationship between a Participant and one other person of the same or opposite sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must be at least 18 years old.
- They must share the same permanent residence and the common necessities of life.
- They must be mentally competent to enter into a contract.
- They must be financially interdependent.

Domiciliary Care - living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

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

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

Eligible Expenses - for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in Section 3, How the Plan Works.

Eligible Expenses are determined solely in accordance with UnitedHealthcare’s reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare’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 UnitedHealthcare accept.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

■ Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
■ Serious impairment to bodily functions.
■ Serious dysfunction of any bodily organ or part.

Emergency Health Services - with respect to an Emergency, both of the following:

■ A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency.
■ Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

Employee Retirement Income Security Act of 1974 (ERISA) - the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Employer - Children's Friend.

EOB - see Explanation of Benefits (EOB).


Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

■ Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
■ Subject to review and approval by any institutional review board for the proposed use.
(Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.)
The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under Clinical Trials in Section 6, Additional Coverage Details.
- If you are not a participant in a qualifying Clinical Trial as described under Section 6, Additional Coverage Details, and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) - a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- The Benefits provided (if any).
- The allowable reimbursement amounts.
- Deductibles.
- Coinsurance.
- Any other reductions taken.
- The net amount paid by the Plan.
- The reason(s) why the service or supply was not covered by the Plan.

Fertility Solutions (FS) - a program administered by UnitedHealthcare or its affiliates made available to you by Children's Friend. The FS program provides:

- Specialized clinical consulting services to Participants and enrolled Dependents to educate on infertility treatment options.
- Access to specialized Network facilities and Physicians for infertility services.

Freestanding Facility - an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society’s certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

**Genetic Testing** - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

**Gestational Carrier** - a Gestational Carrier is a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

**Health Statement(s)** - a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

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

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

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It 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.

**Hospital-based Facility** - an outpatient facility that performs services and submits claims as part of a Hospital.

**Infertility** - A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or Therapeutic Donor Insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women age 35 years or older.

**Injury** - bodily damage other than Sickness, including all related conditions and recurrent symptoms.
**Inpatient Rehabilitation Facility** - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

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

**Intensive Behavioral Therapy (IBT)** - outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI)*.

**Intensive Outpatient Treatment** - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

**Intermittent Care** - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

**Kidney Resource Services (KRS)** - a program administered by UnitedHealthcare or its affiliates made available to you by Children's Friend. The KRS program provides:

- Specialized consulting services to Participants and enrolled Dependents with ESRD or chronic kidney disease.
- Access to dialysis centers with expertise in treating kidney disease.
- Guidance for the patient on the prescribed plan of care.

**Manipulative Treatment** - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

**Medicaid** - a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

**Medically Necessary** – health care services that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:
■ In accordance with Generally Accepted Standards of Medical Practice.
■ Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders disease or its symptoms.
■ Not mainly for your convenience or that of your doctor or other health care provider.
■ Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

**Generally Accepted Standards of Medical Practice** are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the **Generally Accepted Standards of Medical Practice** scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on [www.myuhc.com](http://www.myuhc.com) or by calling the number on your ID card, and to Physicians and other health care professionals on [www.UHCprovider.com](http://www.UHCprovider.com).

**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** - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases* section on Mental and Behavioral Disorders or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases* section on Mental and Behavioral Disorders or *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-Related and Addictive Disorders Administrator** - the organization or individual designated by Children's Friend who provides or arranges Mental Health Services and Substance-Related and Addictive Disorder Services under the Plan.

**Mental Illness** – those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases* section on Mental and Behavioral Disorders or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases* section on
Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Neonatal Resource Services (NRS) - a program administered by UnitedHealthcare or its affiliates made available to you by Children's Friend. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

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

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit Plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, Plan Highlights to determine whether or not your Benefit plan offers Network Benefits and Section 3, How the Plan Works, for details about how Network Benefits apply.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

Non-Medical 24-Hour Withdrawal Management - An organized residential service, including those defined in American Society of Addiction Medicine (ASAM), providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

Open Enrollment - the period of time, determined by Children's Friend, during which eligible Participants may enroll themselves and their Dependents under the Plan. Children's Friend determines the period of time that is the Open Enrollment period.
**Out-of-Pocket Maximum** - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every calendar year. Refer to Section 5, Plan Highlights for the Out-of-Pocket Maximum amount. See Section 3, How the Plan Works for a description of how the Out-of-Pocket Maximum works.

**Partial Hospitalization/Day Treatment** - a structured ambulatory program that may be a freestanding or Hospital-based program and that provides services for at least 20 hours per week.

**Participant** - a full-time Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under Eligibility in Section 2, Introduction. A Participant must live and/or work in the United States.

**Personal Health Support** - programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

**Personal Health Support Nurse** - the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

**Pharmaceutical Product(s)** – U.S. Food and Drug Administration (FDA)-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

**Physician** - any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

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

**Plan** - The Children's Friend Medical Plan.

**Plan Administrator** - Children's Friend or its designee.

**Plan Sponsor** - Children's Friend.

**Pregnancy** - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with the above.
**Prescription Drug List (PDL) Management Committee** - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Pharmaceutical Products into specific tiers.

**Presumptive Drug Test** - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

**Private Duty Nursing** - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or a home setting when any of the following are true:

- Services exceed the scope of Intermittent Care in the home.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.
- Skilled nursing resources are available in the facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

**Reconstructive Procedure** - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

**Residential Treatment** - treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility 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-Related and Addictive Disorders Services 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.
- Referral and orientation to specialized community resources.

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

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

**Shared Savings Program** - a program in which UnitedHealthcare may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider and a third party vendor. When this program applies, the non-Network provider's billed charges will be discounted. Plan coinsurance and any applicable deductible would still apply to the reduced charge. Sometimes Plan provisions or administrative practices supersede the scheduled rate, and a different rate is determined by UnitedHealthcare.

This means, when contractually permitted, the Plan may pay the lesser of the Shared Savings Program discount or an amount determined by UnitedHealthcare, such as:

- A percentage of the published rates allowed by the *Centers for Medicare and Medicaid Services* (CMS) for the same or similar service within the geographic market.
- An amount determined based on available data resources of competitive fees in that geographic area.
- A fee schedule established by a third party vendor.
- A negotiated rate with the provider.

In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

**Sickness** - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

**Skilled Care** - skilled nursing, teaching, and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- A Physician orders them.
- They are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- They require clinical training in order to be delivered safely and effectively.
- They are not Custodial Care, as defined in this section.
Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spouse - an individual to whom you are legally married or a Domestic Partner as defined in this section.

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a disorder is listed in the edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg the surrogate is biologically (genetically) related to the child.

Therapeutic Donor Insemination (TDI) - Insemination with a donor sperm sample for the purpose of conceiving a child.

Transitional Living - Mental health services and substance-related and addictive disorders services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in American Society of Addiction Medicine (ASAM) criteria, that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

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

Unproven Services - health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.
Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.

Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care - Care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center - a facility 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.
SECTION 15 - OUTPATIENT PRESCRIPTION DRUGS

What this section includes:
- Benefits available for Prescription Drug Products.
- How to utilize the retail and mail order service for obtaining Prescription Drug Products.
- Any Benefit limitations and exclusions that exist for Prescription Drug Products.
- Definitions of terms used throughout this section related to the Prescription Drug Product Plan.

Benefits for Prescription Drug Products
Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List (PDL) the Prescription Drug Product is listed. Refer to the Outpatient Prescription Drug Schedule of Benefits for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

What You Must Pay
Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Drug Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Drug Deductible.

Benefits for Prescription Drug Products on the List of Preventive Medications are not subject to payment of the Annual Deductible.

Benefits for Preventive Care Medications are not subject to payment of the Annual Deductible.

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Payment Information - Outpatient Prescription Drugs table or Schedule of Benefits - Outpatient Prescription Drugs, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your request and there is another drug that is Chemically Equivalent.

The amount you pay for any of the following under this section will not be included in calculating any Out-of-Pocket Maximum stated in your SPD:
- Copayments for Prescription Drug Products, including Specialty Prescription Drug Products.
- Coinsurance for Prescription Drug Products.
- Ancillary Charges.
- Certain coupons or offers from pharmaceutical manufacturers. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com](http://www.myuhc.com) or by calling the telephone number on your ID card.
- 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 UnitedHealthcare contracted rates (Prescription Drug Charge) will not be available to you.

### Payment Terms and Features - Outpatient Prescription Drugs

#### Prescription Drug Product Coverage Highlights

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

**Note:** The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 6, Additional Coverage Details.

**Coupons:** UnitedHealthcare may not permit certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance or apply to your Annual Drug Deductible. You may access information on which coupons or offers are not permitted through the Internet at [www.myuhc.com](http://www.myuhc.com) or by calling the number on your ID card.

**If a Brand-name Drug Becomes Available as a Generic**

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

**Prior Authorization Requirements**

Before certain Prescription Drug Products are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to obtain prior authorization from UnitedHealthcare or its designee. The reason for obtaining prior authorization from UnitedHealthcare or its designee is to determine if the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service as defined by the Plan.
- It is not an Experimental or Investigational or Unproven Service, as defined in Section 14, Glossary.
The Plan may also require you to obtain prior authorization from UnitedHealthcare or its designee so UnitedHealthcare can determine whether the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, was prescribed by a Specialist Physician.

**Network Pharmacy Prior Authorization**

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from UnitedHealthcare.

If you do not obtain prior authorization from UnitedHealthcare before the Prescription Drug Product is dispensed, you can ask UnitedHealthcare to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from the Plan as described in Section 9, *Claims Procedures*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from UnitedHealthcare before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

To determine if a Prescription Drug Product requires prior authorization, either visit [www.myuhc.com](http://www.myuhc.com) or call the number on your ID card. The Prescription Drug Products requiring prior authorization are subject to UnitedHealthcare's periodic review and modification.

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

UnitedHealthcare may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at [www.myuhc.com](http://www.myuhc.com) or by calling the number on your ID card.
# Schedule of Benefits - Outpatient Prescription Drugs

**Benefit Information for Prescription Drug Products at a Network Pharmacy**

<table>
<thead>
<tr>
<th>Benefit Description and Supply Limits</th>
<th>Percentage of Prescription Drug Charge Payable by the Plan: (Per Prescription Order or Refill):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List (PDL) are assigned to Tier 1, Tier 2 or Tier 3. Please access <a href="http://www.myuhc.com">www.myuhc.com</a> through the Internet or call the telephone number on your ID card to determine tier status.</td>
<td>100% after you pay a:</td>
</tr>
</tbody>
</table>

### Retail

- **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.**

- **A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied.**

- **When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed or days the drug will be delivered.**

<table>
<thead>
<tr>
<th>Tier</th>
<th>Copay</th>
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</thead>
<tbody>
<tr>
<td>Tier-1</td>
<td>$10 Copay</td>
</tr>
<tr>
<td>Tier-2</td>
<td>$35 Copay</td>
</tr>
<tr>
<td>Tier-3</td>
<td>$60 Copay</td>
</tr>
</tbody>
</table>
**Benefit\textsuperscript{1,5}**

<table>
<thead>
<tr>
<th>Description and Supply Limits</th>
<th>Percentage of Prescription Drug Charge Payable by the Plan: (Per Prescription Order or Refill):</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specialty Prescription Drug Products</strong> - The following supply limits apply: As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed or days the drug will be delivered. Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.</td>
<td></td>
</tr>
<tr>
<td>Tier-1</td>
<td>100% after you pay a: $10 Copay</td>
</tr>
<tr>
<td>Tier-2</td>
<td>$35 Copay</td>
</tr>
<tr>
<td>Tier-3</td>
<td>$60 Copay</td>
</tr>
<tr>
<td><strong>Mail Order Network Pharmacy</strong></td>
<td>100% after you pay a:</td>
</tr>
</tbody>
</table>

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. These supply limits do not apply to Specialty Prescription Drug Products, including Specialty Prescription Drug Products on the List of Preventive Medications. Specialty Prescription Drug Products from a Mail Order Network Pharmacy...
Benefit\textsuperscript{1,5} Description and Supply Limits

<table>
<thead>
<tr>
<th>Percentage of Prescription Drug Charge Payable by the Plan: (Per Prescription Order or Refill):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy are subject to the supply limits stated above under the heading Specialty Prescription Drug Products.</td>
</tr>
<tr>
<td>The Plan may allow a 31-day fill at the Mail Order Pharmacy for certain Prescription Drug Products for the Copayment and/or Coinsurance you would pay at a retail Network Pharmacy. You may determine whether a 31-day fill of Prescription Drug Product is available through the Mail Order Pharmacy for a retail Network Pharmacy Copayment and/or Coinsurance through the Internet at <a href="http://www.myuhc.com">www.myuhc.com</a> or by calling the telephone number on your ID card.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tier-1</th>
<th>Tier-2</th>
<th>Tier-3</th>
</tr>
</thead>
<tbody>
<tr>
<td>$20 Copay</td>
<td>$70 Copay</td>
<td>$120 Copay</td>
</tr>
</tbody>
</table>

\textsuperscript{1}Please obtain prior authorization from UnitedHealthcare before receiving Prescription Drug Products, as described in Payment Terms and Features, under Prior Authorization Requirements in this section.

\textsuperscript{5}You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

**Note:** The Coordination of Benefits provision described in Section 10, Coordination of Benefits (COB) applies to covered Prescription Drug Products as described in this section. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in this SPD.

**Identification Card (ID Card) - 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 UnitedHealthcare during regular business hours.
If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

You may seek reimbursement from the Plan as described in Section 9, Claims Procedures, under the heading, If Your Provider Does Not File Your 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 Charge, less the required Copayment and/or Coinsurance, Ancillary Charge, and any deductible that applies.

Submit your claim to:
Optum Rx
PO Box 29077
Hot Spring, AR 71903

**Benefit Levels**
Benefits are available for outpatient Prescription Drug Products that are considered Covered Health Services.

The Plan pays Benefits at different levels for tier-1, tier-2 and tier-3 Prescription Drug Products.

All Prescription Drug Products covered by the Plan are categorized into these three tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Since the PDL may change periodically, you can visit [www.myuhc.com](http://www.myuhc.com) or call UnitedHealthcare at the number on your ID card for the most current information.

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

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

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of:
The applicable Copay.
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product.
- The Prescription Drug Charge for that Prescription Drug Product.

For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of:
- The applicable Copay.
- The Prescription Drug Charge for that particular Prescription Drug.

**Retail**

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy. The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting UnitedHealthcare at the number on your ID card or by logging onto www.myuhc.com.

To obtain your prescription from a Network Pharmacy, simply present your ID card and pay the Copay. The 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.
- A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay the Copay for each cycle supplied.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copay that applies will reflect the number of days dispensed.

If you purchase a Prescription Drug from a non-Network Pharmacy, you will be required to pay full price and will not receive reimbursement under the Plan.

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

**Mail Order**

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy. The mail order service may allow you to purchase up to a 90-day supply of a covered Prescription Drug Product through the mail from a Network Pharmacy.

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

The following supply limits apply: As written by the provider, up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer’s packaging size or based on supply limits.

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

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

Benefits for Preventive Care Medications

Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined, in this section, under Glossary - Prescription Drug Products. You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling UnitedHealthcare at the number on your ID card.

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, UnitedHealthcare may direct you to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Prescription Drug Product.

Smart Fill Program - Split Fill

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Copayment or Coinsurance. The Covered Person will receive a 15-day supply of their Specialty Prescription Drug Product to determine if they will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact the Covered Person each time prior to dispensing the 15-day supply to confirm if the Covered Person is tolerating the Specialty Prescription Drug Product. You may find a list of Specialty Prescription Drug Products included in the Smart Fill Program, through the internet at www.myuhc.com or by calling the telephone number on your ID card.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.
If you require Specialty Prescription Drug Products, UnitedHealthcare may direct you to a Designated Pharmacy with whom UnitedHealthcare has an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Specialty Prescription Drug Product.

Please see Glossary - Outpatient Prescription Drugs, for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

Refer to the Outpatient Prescription Drug Schedule of Benefits for details on Specialty Prescription Drug Product supply limits.

Please see Glossary - Outpatient Prescription Drugs, in this section for definitions of Specialty Prescription Drug Product and Designated Pharmacy.

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

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**Assigning Prescription Drug Products to the Prescription Drug List (PDL)**

UnitedHealthcare's Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on UnitedHealthcare's behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are most cost effective for specific indications as compared to others, therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

The PDL Management Committee may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.
Note: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access www.myuhc.com through the Internet or call the number on your ID card for the most up-to-date tier status.

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

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

Prescription Drug Benefit Claims
For Prescription Drug Product claims procedures, please refer to Section 9, Claims Procedures.

Limitation on Selection of Pharmacies
If UnitedHealthcare determines that you may be 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, UnitedHealthcare 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 don't make a selection within 31 days of the date the Plan Administrator notifies you, UnitedHealthcare will select a single Network Pharmacy for you.

Supply Limits
Benefits for Prescription Drug Products are subject to supply limits that are stated in the table under the heading Prescription Drug Product Coverage Highlights. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Whether or not a Prescription Drug Product has a supply limit is subject to UnitedHealthcare's periodic review and modification.

Note: Some products are subject to additional supply limits based on criteria that the Plan Administrator and UnitedHealthcare have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing, through the Internet at www.myuhc.com or by calling the telephone number on your ID card.

Special Programs
Children's Friend and UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health...
management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling the number on your ID card.

**Prescription Drug Products Prescribed by a Specialist Physician**

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

**Step Therapy**

Certain Prescription Drug Products for which Benefits are described in this section are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

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

**Prescription Drug Products that are Chemically Equivalent**

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

**Rebates and Other Discounts**

UnitedHealthcare and Children's Friend may, at times, receive rebates for certain drugs included on the PDL, including those drugs that you purchase prior to meeting any applicable deductible. As determined by UnitedHealthcare, the Plan may pass a portion of these rebates on to you. When rebates are passed on to you they may be taken into account in determining your Copayment and/or Coinsurance.

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

**Coupons, Incentives and Other Communications**

At various times, UnitedHealthcare may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including
information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, at your discretion, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

**Exclusions - What the Prescription Drug Plan Will Not Cover**

Exclusions from coverage listed in Section 8, *Exclusions and Limitations* also apply to this section. In addition, the exclusions listed below apply.

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

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

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

3. Pharmaceutical Products for which Benefits are provided in the medical (not in Section 15, *Outpatient Prescription Drugs*) portion of the Plan.

   This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

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

5. Compounded drugs that contain certain bulk chemicals. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3) Compounded drugs that are available as a similar commercially available Prescription Drug Product.

6. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.

8. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your SPD. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.


10. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

11. The amount dispensed (days’ supply or quantity limit) which exceeds the supply limit.

12. The amount dispensed (days’ supply or quantity limit) which is less than the minimum supply limit.

13. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

14. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Claims Administrator's Prescription Drug List (PDL) Management Committee.

15. Prescribed, dispensed or intended for use during an Inpatient Stay.

16. Prescribed, dispensed for appetite suppression, and other weight loss products.

17. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that UnitedHealthcare and Children's Friend determines do not meet the definition of a Covered Health Service.

18. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

19. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

20. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by UnitedHealthcare. Such determinations may be made up to six times during a calendar year, and
UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

21. Certain unit dose packaging or repackers of Prescription Drug Products.

22. Used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless UnitedHealthcare and Children's Friend have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in Section 14, Glossary.

23. Used for cosmetic purposes

24. General vitamins, except for the following which require a Prescription Order or Refill:
   - Prenatal vitamins.
   - Vitamins with fluoride.
   - Single entity vitamins.

25. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury.

26. A Prescription Drug Product that contains marijuana, including medical marijuana.

27. Dental products, including but not limited to prescription fluoride topicals.

28. A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

29. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

30. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

31. Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.
Glossary - Outpatient Prescription Drugs

Ancillary Charge - a charge, in addition to the Copayment that you are required to pay when a covered Prescription Drug Product is dispensed at your request, when a Chemically Equivalent Prescription Drug Product is available. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Product Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product, and the Prescription Drug Product Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product.

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 UnitedHealthcare identifies as a Brand-name product, based on available data resources including, but not limited to, medi-span or 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 UnitedHealthcare.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with UnitedHealthcare or with an organization contracting on its behalf, to provide specific Prescription Drug Products including, but not limited to, Specialty Prescription Drug Products. 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 UnitedHealthcare identifies as a Generic product based on available data resources including, but not limited to, medi-span or 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 "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by UnitedHealthcare.

Infertility - failure to achieve a Pregnancy after a year of regular unprotected intercourse if the woman is under age 35, or after six months if the woman is over age 35. In addition, in order to be eligible for Benefits, the Covered Person must also:

■ Be under age 44, if female.
■ Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.

List of Preventive Medications - a list that identifies certain Prescription Drug Products, which may include certain Specialty Prescription Drug Products, on the Prescription Drug List (PDL) that are intended to reduce the likelihood of Sickness. You may obtain the List of Preventive Medications through the Internet at www.myuhc.com or by calling the number on your ID card.
**Maximum Allowable Cost (MAC) List** - a list of Generic Prescription Drug Products that will be covered at a price level that UnitedHealthcare establishes. This list is subject to UnitedHealthcare's periodic review and modification.

**Network Pharmacy** - a pharmacy that has:
- Entered into an agreement with UnitedHealthcare or an organization contracting on its behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by UnitedHealthcare as a Network 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 U.S. Food and Drug Administration (FDA) and ending on the earlier of the following dates:
- The date it is assigned to a tier by UnitedHealthcare's Prescription Drug List (PDL) Management Committee.
- December 31st of the following calendar year.

**Out-of-Pocket Drug Maximum** - the maximum amount you are required to pay for covered Prescription Drug Products in a single year. Refer to the Outpatient Prescription Drug Benefit Information table for details about how the Out-of-Pocket Drug Maximum applies.

**Prescription Drug Charge** - the rate the Plan has agreed to pay UnitedHealthcare on behalf of its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

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

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

**Prescription Drug Product** - a medication, or product that has been approved by the U.S. Food and Drug Administration (FDA) 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 purposes of Benefits under this Plan, this definition includes:
Inhalers (with spacers).

Insulin.

The following diabetic supplies:
- Standard insulin syringes with needles.
- Blood-testing strips - glucose.
- Urine-testing strips - glucose.
- Ketone-testing strips and tablets.
- Lancets and lancet devices.
- Glucose meters including continuous glucose monitors.
- Certain vaccines/immunizations administered in a Network Pharmacy.

**Prevention 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.

**Preventive Care Medications (PPACA Zero Cost Share)** - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.

- 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.

- You may determine whether a drug is a Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives through the internet at [www.myuhc.com](http://www.myuhc.com) or by calling UnitedHealthcare at the telephone number on your ID card.

- For the purposes of this definition PPACA means Patient Protection and Affordable Care Act of 2010.

**Specialist Physician** - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

**Specialty Prescription Drug Product** - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products include certain drugs for Infertility. Specialty Prescription Drug Products may include drugs on the List of Preventive Medications. You
may access a complete list of Specialty Prescription Drug Products through the Internet at www.myuhc.com or by calling the number on your ID card.

**Therapeutically Equivalent** - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

**Usual and Customary Charge** - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.
SECTION 16 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:

- Plan administrative information, including your rights under ERISA.

This section includes information on the administration of the medical Plan, as well as information required of all Summary Plan Descriptions by ERISA as defined in Section 14, Glossary. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Administrator

Children’s Friend is the Plan Sponsor and Plan Administrator of the Children’s Friend Welfare Benefit Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Administrator - Medical Plan
Children’s Friend
153 Summer St
Providence, RI 02903
(401) 276-4324

Claims Administrator

UnitedHealthcare is the Plan’s Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan’s coverage as directed by the Plan Administrator, through an administrative agreement with the Company. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor’s Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

United Healthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Agent for Legal Process - Medical Plan
Children’s Friend
153 Summer St
Providence, RI 02903
(401) 276-4324
Legal process may also be served on the Plan Administrator.

**Other Administrative Information**
This section of your SPD contains information about how the Plan is administered as required by ERISA.

**Type of Administration**
The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

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<tr>
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<td>Assets of the Company</td>
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</table>

**Your ERISA Rights**
As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- Receive information about Plan Benefits.
- Examine, without charge, at the Plan Administrator’s office and at other specified worksites, all plan documents — including pertinent insurance contracts, collective bargaining agreements (if applicable), and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies. Requests for available plan documents should be sent to the address provided under How to Appeal a Denied Claim in Section 9, Claims Procedures.

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the Plan documents to understand the rules governing your COBRA continuation coverage rights.
In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under ERISA.

If your claim for a Plan Benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See Section 9, Claims Procedures, for details.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document from the Plan, and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $147 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272.

The Plan's Benefits are administered by Children's Friend, the Plan Administrator. UnitedHealthcare is the Claims Administrator and processes claims for the Plan and provides appeal services; however, UnitedHealthcare and Children's Friend are not responsible for any decision you or your Dependents make to receive treatment, services or supplies, whether provided by a Network or non-Network provider UnitedHealthcare and Children's Friend are neither liable nor responsible for the treatment, services or supplies provided by Network or non-Network providers.
ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

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

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, the Plan provides 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.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

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

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

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

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

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your issuer.
ATTACHMENT III – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United Healthcare, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

<table>
<thead>
<tr>
<th>Claims Administrator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Civil Rights Coordinator</td>
</tr>
</tbody>
</table>

United HealthCare Services, Inc. Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130
The toll-free member phone number listed on your health plan ID card, TTY 711

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.
You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf


Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

### ATTACHMENT IV – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

<table>
<thead>
<tr>
<th>Language</th>
<th>Translated Taglines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Albanian</td>
<td>Ju keni të drejto merrni ndihmë dhe informacion filas në gjuhën tua. Për të kërkuar një përshtyes, telefononi në numrin që gendet në karta e planit tuaj shëndetësor, shtypni 0. TTY 711.</td>
</tr>
</tbody>
</table>
| 2. Amharic         | እንደ ይ printk ያлеж ምትራንት ያለው ከአማርኛ ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለከተሆን ከምር ከመለケース
<table>
<thead>
<tr>
<th>Language</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burmese</td>
<td>ကျွန်ုပ်တို့၏ ကိစ္စအကြောင်း ကျေးဇူးအပေါ် ရှိသော လူမှုများကို အတန်းပေးသော အချက်အလက်များ။ အချက်အလက်များအတွက် 0 ထုတ်လုပ် TTY 711</td>
</tr>
<tr>
<td>Cambodian-Mon-Khmer</td>
<td>ព្រេងអំពើនថ្ន សីអេុលអាហារ ភ្ននៅពេលព្រាចារ 0- TTY 711 46</td>
</tr>
<tr>
<td>Cherokee</td>
<td>ß' D4ø3 ⦃F, JcZp. T, j4ø©+ıA9W8i t-GTP-A, ø4Fr: IJ7. I AC60A. I: 04061, 0: TTY 711 46</td>
</tr>
<tr>
<td>Chinese</td>
<td>您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免費獲取電話號碼，再按 0。聽力腫音障礙服務專線 711 46</td>
</tr>
<tr>
<td>Choctaw</td>
<td>Chik' 7ampe ya. apel uchta nek auna yán a ahi hnu a ho isha a ynl a chu kët a chu oln a. Toshilta ak ishka chu hekmt chu chu kët a chu. 7ampe hnu a chu 7ampe ya chu 7ampe chu 7ampe chu chu oln a chu chu chu. TTY 711 46</td>
</tr>
<tr>
<td>Cushite-Oromo</td>
<td>Kaflätti maale 6a aamint ooseffanno 6c daggass argachuff-migaa ni gaabbi. Turjumama ga aachuff saa bilbaa a kan billisa-vatiga seenoo maaro fayva keemtit tansefame billiuluun. 0. TTY 711 46</td>
</tr>
<tr>
<td>Dutch</td>
<td>U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringkaart treft, druk op 0. TTY 711 46</td>
</tr>
<tr>
<td>French</td>
<td>Vous avez le droit d’obtenir gratuitement l’aide et des renseignements dans votre langue. Pour demander un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d’assédé du régime de soins de santé et appuyez sur la touche 0. ATS 711 46</td>
</tr>
<tr>
<td>French-Creole-Haitian-Creole</td>
<td>Ou gen dwa pou-jenn ed ak enfomasyon nan lang-natatinal ou-gutsis. Pou mande yon entepret, sele nymevo-gutsis mann-nlan ki endikey sou kat 1D plan sante ou, peze 0. TTY 711 46</td>
</tr>
<tr>
<td>German</td>
<td>Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an. 46</td>
</tr>
<tr>
<td>Attachment IV - Getting Help in Other Languages or Formats</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>18. Greek</strong></td>
<td></td>
</tr>
</tbody>
</table>
| Εγγυάζομαι να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε βοήθεια, καλέστε το διακέπτη 911  
| υπηρεσίας 911 χρησιμοποιώντας την επικοινωνία μέσω τηλεφώνημας, παρατηρήστε 0-TTY711. |
| **19. Gujarati**  |
| રામની માતુલ સૂચિ અને તેમાં સહેજતા મેળવવા માટેની મદદદારતા અધિકાર છે. જવાબદાર હેડ ફોલ્ડ ID કે ચકાસક સુધીમાંથી અપલેટ ધોઈ શકી શકો છો, 0 6 9 9 6 9 7 0 7 1 1. |
| **20. Hawaiian**  |
| He pono ke kōkuʻa ʻana aku iaʻoe ma ka maopopo ʻana o keia ike ma loko o kaʻauʻoelelo ponoʻi me ka ʻukuʻoleʻana.  
E kaʻaʻiloʻoe me keʻakai kanaka umuhi, e kākea i ka helu telepona kākīʻole ma kou kāleka olakino, a e kaʻome ia helu 0. TTY711. |
| **21. Hindi**  |
| आपके लिए आपनी भाषा के साथ सहायता प्रदान करने के लिए अनुपूर्ण आपकी सुविधा प्रदान करने के लिए अनुसूची तैयार करने के लिए, आपके हॉस्पिटल ID कार्ड पर सूचित डोक्यां नंबर पर की जाती है, 0 6 9 9 6 9 7 0 7 1 1. |
| **22. Ilonggo**  |
| Ko ko maja cauir pah tiabt sau o koj hom lus pah dabt. Yotgaw tiab tig neq tshais, hu tus otooj sau tswa cuahbu dabt sau maja sawbntawm koj dain tway them ni kho-mob, mi 0. TTY711. |
| **23. Ibo**  |
| Inwere iikwe inweta enyemaka nakwa imuta asu su gi niefu nako kwa uguwo. Maka ikiwutu onye mughaisi okwu, kpo akara ekwenti nke di nakwubwo njimara gi nke emere maka ajujahe gi, pia 0. TTY711. |
| **24. Ilocano**  |
| Anda harbeng-mga mahasalatulong sa tulong kan impormasyon itipagbasasoy mga libre. Tapos ayaw ni maya nga akipatarus, tumawag ni tali-free nga numero ti telepono nga para kadagit kameng mga nakasalita ayan ti ID card ni para ti plano ti salamat, spindat ti 0. TTY711. |
| **25. Indonesian**  |
| Anda bisa untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY711. |
| **26. Italian**  |
| Ha il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti /TTY:711. |
CHILDREN’S FRIEND MEDICAL ASO NAVIGATE GIL $750 MOD

27. Japanese

ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのIDカードに記載されているメンバー用のフリーダイヤルまでお電話を、0を押してください。TTY専用番号は711です。

28. Karen

Klar ab learning words in Karen. Please call the Karen customer service number for help.

29. Korean

귀하는 도움과 정보를 귀하의 언어로 비문부대기에 언제든지 연락해 주시기 바랍니다. 통역을 요청하기 위해서는 귀하의 음성 ID카드에 기재된 무료 회원 연락번호로 연락하여 0번을 누르십시오. TTY 7110.

30. Kru-Bassa

Nigwe konde I bat mahok ni mawin u-hop nan nuphemes be to dolla. Yukuwe ni Kobol mahop sebiana, soho nu sebe numa la telenu m-f
ticket I doctu I nan, bep 0. TTY 7110.

31. Kurdish

ماشین آموزش جهاد قرار گرفتگری، روزانه در زبان زیستی به زبان کردی نوشته شود. ترجمه ترجمه کردی ترجمه ترجمه TTY 7110.

32. Lao

คำข้อความด้านล่างเป็นภาษาลาวทางภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาภาษาประกาศ TTY 7110.

33. Marathi

आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचा आयुर्विज्ञानाचা TTY 7110.

34. Marshallese

Eor am maroa lan bok i papa m melo i lo sain eo am i elo ile:le woa. Nane kajitok i lan jou ni ukok, kudok noma eo e mojan ile:le loa in ID in kork in ajmou eo am, iped 0. TTY 7110.

35. Micronesian Pohnpeian

Kom-lohni ko manaman unus kom-loh ni ile:le sava os mengile:le ni pein omor tungel loa in so isi:le. Pwen peki sava os voan kaweloe, eker depe wohn nema oje towelni ko so isi:le me nangile:le ni pein omor dero ogeme ko kid koos andi en keli, padik 0. TTY 7110.

36. Navajo

Tsáal'íil'í hoo doo bájá' alingóó bee bas hante'íí t'é áá ni nízaad bee: níka'a eyego bee máshoof'. 'Ata'al sine'i' ya yinkéedgo, nimal-koos: níz't? 'Ata'7i' bee bas'ライブå' bee máshóózin' g7' báñiñ' b'4ísh bee-hane' t'é 11717h kee bee hane' báñiñ' b'171' g7? báñiñ' b'kökináhíi d60' bii-
<table>
<thead>
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<tr>
<td>Nepali</td>
<td>तपाईंले आफैले बालको चिकित्सा भुगतान र सहयोग जस्तै हामीले प्रदान गर्ने अधिकार तपाईंले अन्य अन्य भनने उपलब्ध नन्दीले, तपाईले सृजनस्तिविधि प्रस्तुतीकरणका साथै कामहरूले सृजनस्तिविधिलाई डोका दिन सहयोग र सहभाग तथा सहयोगको गतिशीलता नहुनुहोस्। TTY: 711</td>
</tr>
<tr>
<td>Nilotic Dinka</td>
<td>Yin nag lorg be ye kwony ne wöer tuc de thog du abac ke in woe tauc ke tuiy. Acan ba ran ye hoc ger thok theec ke yin col namba yene yup abac de ran tög ye hoc wärthuk tu-né ID kat duon de panakim yic; thiny 0-6: yic TTY: 711.</td>
</tr>
<tr>
<td>Norwegian</td>
<td>Ditt har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer: oppført på helsekortet og trykk 0. TTY: 711</td>
</tr>
<tr>
<td>Pennsylvania Dutch</td>
<td>Do hoescht die Recht der Hulp van Information in dein Schproochbige, fer ni. Wann du en formenstructuwe willicht, kannicht du die fer Telefon Nummer uff dei Gesundheit Blan ID Kaarde ymuze; drieck 0. TTY: 711</td>
</tr>
<tr>
<td>Persian-Farsi</td>
<td>كما هواردکه کمک و اطلاعات به زبان خود را به طور رایگان دریافت می‌توانید. برای دریافت هرکجا شما اطلاعات نشان می‌دهید TTY: 711</td>
</tr>
<tr>
<td>Punjabi</td>
<td>ਪੰਜਾਬੀ ਲੇਖ ਨੂੰ ਖਿਆਲ ਨਹੀਂ ਲੈਂਦਾ ਜਿਸ ਦੇ ਥਾਂਕੜ ਪੁਲਾਵ ਨਾਲ ਪੰਜੀਕਰਨ ਨੀ</td>
</tr>
<tr>
<td>Polish</td>
<td>Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadawon pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY: 711</td>
</tr>
<tr>
<td>Portuguese</td>
<td>Você tem o direito de obter ajuda e informação em seu idioma e sem custo. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY: 711</td>
</tr>
<tr>
<td>Romanian</td>
<td>Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tastă 0. TTY: 711</td>
</tr>
<tr>
<td>Russian</td>
<td>Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика,</td>
</tr>
<tr>
<td>Language</td>
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<td>----------------------------------------------------------------------</td>
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</table>
| Samoan        | E vai louai titau e manu atuia te fono o fa'amatalaga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i leuga i lega ...
<table>
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</thead>
<tbody>
<tr>
<td>Farsi</td>
<td>روزگاری نکوداشتی است که افراد از طریق ارتباط با یکدیگر بهبود یافته بهبود دریافت می‌کنند.</td>
</tr>
<tr>
<td>Swahili</td>
<td>Mtu waomu punguzungu kupa wajumla una amaswa nchini echewa amaswa nchini epe wa uwewe, wengine wamepata fomu, ese kamo thika hana kujifunza tuungane amaswa chakuka, kon wewe member mampi, ese pwan kamo, ni pochungu wanda amaswa health plan hataen ID, iwe tiki &quot;0&quot;. Ren TTY, kon 711.</td>
</tr>
<tr>
<td>Turkish</td>
<td>Kendi dilinde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık plasımı kimlik kartınızı üzerinde yer alan ticket siz telefon mamara satin alırsınız, sonra o'a basın. TTY (yardıım iletişim) için 711.</td>
</tr>
<tr>
<td>Ukrainian</td>
<td>У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб позитивно запит про надання послуг-перекладача, звоніть нам безкоштовний номер телефону участника, зазначений на вашій ідентифікаційній картці плану-майданчого страхування, натисніть 0. TTY 711.</td>
</tr>
<tr>
<td>Urdu</td>
<td>آپ کو اپنے زیر حفاظت میں ہے۔ لہذا، آپ کو مبتلا ہوئے کتابوں کے ساتھ بہتر ہوئے ہیں، اور آپ کے کیہان ہیں۔ 0 TTY 711.</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>Quý vị có quyền được grup ô và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch văn giấy ô, quý vị gọi số điện thoại miễn phí của họ để nhận được thẻ ID-cho trong hành chính nước tế của quý vị, bấm số 0. TTY 711.</td>
</tr>
</tbody>
</table>
| Yiddish | לייזנ ויייזנ שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיבرנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיברנען דעם העריך שיבرנען דעם העריך שיברנען דעם העריך שיברנع
ADDENDUM – REAL APPEAL

This Addendum to the Plan provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.

Real Appeal

The Plan provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 18 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

These Covered Health Services will be individualized and may include, but is not limited to, the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like information regarding these Covered Health Services, you may contact the Claims Administrator through www.realappeal.com, or at the number shown on your ID card.
Children's Friend and Service

Your Group Life and Accidental Death and Dismemberment Plan

Identification No. 395970 012

Underwritten by Unum Life Insurance Company of America

1/22/2013
CERTIFICATE OF COVERAGE

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the Summary of Benefits (issued to the Employer), the Summary of Benefits will govern. The Summary of Benefits may be changed in whole or in part. Only an officer or registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to the Summary of Benefits. Any other person, including an agent, may not change the Summary of Benefits or waive any part of it.

The Summary of Benefits is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. When making a benefit determination under the Summary of Benefits, Unum has discretionary authority to determine your eligibility for benefits and to interpret the terms and provisions of the Summary of Benefits.

For purposes of effective dates and ending dates under the group Summary of Benefits, all days begin at 12:01 a.m. and end at 12:00 midnight at the Employer's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122
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BENEFITS AT A GLANCE

LIFE INSURANCE PLAN

This life insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death. The amount your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death according to the terms and provisions of the plan.

EMPLOYER'S ORIGINAL PLAN
EFFECTIVE DATE: January 1, 2013

IDENTIFICATION NUMBER: 395970 012

ELIGIBLE GROUP(S):
All Full-Time Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:
Employees must be working at least 20 hours per week.

WAITING PERIOD:
For employees in an eligible group on or before January 1, 2013: None
For employees entering an eligible group after January 1, 2013: First of the month coincident with or next following the date you enter an eligible group

REHIRE:
If your employment ends and you are rehired within 1 year, your previous work while in an eligible group will apply toward the waiting period. All other Summary of Benefits' provisions apply.

WHO PAYS FOR THE COVERAGE:
Your Employer pays the cost of your coverage.

ELIMINATION PERIOD:
Premium Waiver: 9 months
Disability-based benefits begin the day after Unum approves your claim and the elimination period is completed.

LIFE INSURANCE BENEFIT:

AMOUNT OF LIFE INSURANCE FOR YOU
1 x annual earnings
All amounts are rounded to the next higher multiple of $1,000, if not already an exact multiple thereof.

AMOUNT OF LIFE INSURANCE AVAILABLE IF YOU BECOME INSURED AT CERTAIN AGES OR HAVE REACHED CERTAIN AGES WHILE INSURED
If you have reached age 65, but not age 70, your amount of life insurance will be:
- 65% of the amount of life insurance you had prior to age 65; or
- 65% of the amount of life insurance shown above if you become insured on or after age 65 but before age 70.
There will be no further increases in your amount of life insurance.

If you have reached age 70, but not age 75, your amount of life insurance will be:
- 50% of the amount of life insurance you had prior to your first reduction; or
- 50% of the amount of life insurance shown above if you become insured on or after age 70 but before age 75.

There will be no further increases in your amount of life insurance.

If you have reached age 75 or more, your amount of life insurance will be:
- 35% of the amount of life insurance you had prior to your first reduction; or
- 35% of the amount of life insurance shown above if you become insured on or after age 75.

There will be no further increases in your amount of life insurance.

MAXIMUM BENEFIT OF LIFE INSURANCE FOR YOU:

$150,000

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

   Accelerated Benefit
   Conversion
   Portability

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section. The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.
BENEFITS AT A GLANCE
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN

This accidental death and dismemberment insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death or for you in the event of any other covered loss. The amount you or your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death or any other covered loss according to the terms and provisions of the plan.

EMPLOYER’S ORIGINAL PLAN
EFFECTIVE DATE: January 1, 2013

IDENTIFICATION NUMBER: 395970 012

ELIGIBLE GROUP(S):

All Full-Time Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 20 hours per week.

WAITING PERIOD:

For employees in an eligible group on or before January 1, 2013: None
For employees entering an eligible group after January 1, 2013: First of the month coincident with or next following the date you enter an eligible group

REHIRE:

If your employment ends and you are rehired within 1 year, your previous work while in an eligible group will apply toward the waiting period. All other Summary of Benefits’ provisions apply.

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT:

AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE FOR YOU (FULL AMOUNT)

1 x annual earnings

All amounts are rounded to the next higher multiple of $1,000, if not already an exact multiple thereof.

AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE AVAILABLE IF YOU BECOME INSURED AT CERTAIN AGES OR HAVE REACHED CERTAIN AGES WHILE INSURED

If you have reached age 65, but not age 70, your amount of AD&D insurance will be:
- 65% of the amount of AD&D insurance you had prior to age 65; or
- 65% of the amount of AD&D insurance shown above if you become insured on or after age 65 but before age 70.

There will be no further increases in your amount of AD&D insurance.

If you have reached age 70, but not age 75, your amount of AD&D insurance will be:
- 50% of the amount of AD&D insurance you had prior to your first reduction; or
- 50% of the amount of AD&D insurance shown above if you become insured on or after age 70 but before age 75.
There will be no further increases in your amount of AD&D insurance.

If you have reached age 75 or more, your amount of AD&D insurance will be:
- 35% of the amount of AD&D insurance you had prior to your first reduction; or
- 35% of the amount of AD&D insurance shown above if you become insured on or after age 75.

There will be no further increases in your amount of AD&D insurance.

MAXIMUM BENEFIT OF ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE FOR YOU:

$150,000

REPATRIATION BENEFIT FOR YOU

Maximum Benefit Amount:
Up to $5,000

The Repatriation Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Repatriation Benefit, your accidental death benefit must be paid first.

SEATBELT(S) AND AIR BAG BENEFIT FOR YOU

Benefit Amount:
Seatbelt(s): 10% of the Full Amount of your accidental death and dismemberment insurance benefit.
Air Bag: 5% of the Full Amount of your accidental death and dismemberment insurance benefit.

Maximum Benefit Payment:
Seatbelt(s): $25,000
Air bag: $5,000

The Seatbelt(s) and Air Bag Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Seatbelt(s) and Air Bag Benefit, your accidental death benefit must be paid first.

EDUCATION BENEFIT

Each Qualified Child

Benefit Amount per Academic Year for which a Qualified Child is enrolled:
6% of the Full Amount of the employee's accidental death and dismemberment insurance to a maximum of $6,000.

Maximum Benefit Payments:
4 per lifetime

Maximum Benefit Amount:
$24,000

Maximum Benefit Period:
6 years from the date the first benefit payment has been made.
The Education Benefit is separate from any accidental death and dismemberment benefit which may be payable. In order for your Qualified Child to receive the Education Benefit, your accidental death benefit must be paid first.

EXPOSURE AND DISAPPEARANCE BENEFIT FOR YOU

Maximum Benefit Amount: The Full Amount

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Portability

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section. The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.
CLAIM INFORMATION

LIFE INSURANCE

WHEN DO YOU OR YOUR AUTHORIZED REPRESENTATIVE NOTIFY UNUM OF A CLAIM?

We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on your disability, written notice and proof of claim must be sent no later than 90 days after the end of the elimination period.

If a claim is based on death, written notice and proof of claim must be sent no later than 90 days after the date of death.

If it is not possible to give proof within these time limits, it must be given no later than 1 year after the proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

The claim form is available from your Employer, or you or your authorized representative can request a claim form from us. If you or your authorized representative does not receive the form from Unum within 15 days of the request, send Unum written proof of claim without waiting for the form.

If you have a disability, you must notify us immediately when you return to work in any capacity, regardless of whether you are working for your Employer.

HOW DO YOU FILE A CLAIM FOR A DISABILITY?

You or your authorized representative, and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

If your claim is based on your disability, your proof of claim, provided at your expense, must show:

- that you are under the regular care of a physician;
- the date your disability began;
- the cause of your disability;
- the extent of your disability, including restrictions and limitations preventing you from performing your regular occupation or any gainful occupation; and
- the name and address of any hospital or institution where you received treatment, including all attending physicians.

We may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 45 days of a request by us.
If claim is based on death, proof of claim, provided at your or your authorized representative’s expense, must show the cause of death. Also a certified copy of the death certificate must be given to us.

In some cases, you will be required to give Unum authorization to obtain additional medical and non-medical information as part of your proof of claim or proof of continuing disability. Unum will deny your claim if the appropriate information is not submitted.

WHEN CAN UNUM REQUEST AN AUTOPSY?

In the case of death, Unum will have the right and opportunity to request an autopsy where not forbidden by law.

HOW DO YOU DESIGNATE OR CHANGE A BENEFICIARY? (Beneficiary Designation)

At the time you become insured, you should name a beneficiary on your enrollment form for your death benefits under your life insurance. You may change your beneficiary at any time by filing a form approved by Unum with your Employer. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before your Employer receives that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, Unum has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If we are to make payments to a beneficiary who lacks the legal capacity to give us a release, Unum may pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This payment made in good faith satisfies Unum’s legal duty to the extent of that payment and Unum will not have to make payment again.

Also, at Unum’s option, we may pay up to $1,000 to the person or persons who, in our opinion, have incurred expenses for your last sickness and death.
HOW WILL UNUM MAKE PAYMENTS?

If your life claim is at least $10,000, Unum will make available to the beneficiary a retained asset account (the Unum Security Account).

Payment for the life claim may be accessed by writing a draft in a single sum or drafts in smaller sums. The funds for the draft or drafts are fully guaranteed by Unum.

If the life claim is less than $10,000, Unum will pay it in one lump sum to your beneficiary.

Also, your beneficiary may request the life claim to be paid according to one of Unum’s other settlement options. This request must be in writing in order to be paid under Unum’s other settlement options.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud; and
- any error Unum makes in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

WHAT ARE YOUR ASSIGNABILITY RIGHTS FOR THE DEATH BENEFITS UNDER YOUR LIFE INSURANCE? (Assignability Rights)

The rights provided to you by the plan for life insurance are owned by you, unless:

- you have previously assigned these rights to someone else (known as an ‘assignee’); or
- you assign your rights under the plan(s) to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by you, and acceptable to us in form; and
- a signed or certified copy of the written assignment has been received and registered by us at our home office.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan(s’) provisions before receiving and registering an assignment.
CLAIM INFORMATION

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

WHEN DO YOU OR YOUR AUTHORIZED REPRESENTATIVE NOTIFY UNUM OF A CLAIM?

We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on death or other covered loss, written notice and proof of claim must be sent no later than 90 days after the date of death or the date of any other covered loss.

If a claim is based on the Education Benefit, written notice and proof of claim must be sent no later than 60 days after the date of your death.

If it is not possible to give proof within these time limits, it must be given no later than 1 year after the time proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

The claim form is available from your Employer, or you or your authorized representative can request a claim form from us. If you or your authorized representative does not receive the form from Unum within 15 days of your request, send Unum written proof of claim without waiting for the form.

HOW DO YOU FILE A CLAIM FOR A COVERED LOSS?

You or your authorized representative and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

WHAT INFORMATION IS NEEDED AS PROOF OF CLAIM?

If claim is based on death or other covered loss, proof of claim for death or covered loss, provided at your or your authorized representative’s expense, must show:

- the cause of death or covered loss;
- the extent of the covered loss;
- the date of covered loss; and
- the name and address of any hospital or institution where treatment was received, including all attending physicians.

Also, in case of death, a certified copy of the death certificate must be given to us.

In some cases, you will be required to give Unum authorization to obtain additional medical and non-medical information as part of your proof of claim. Unum will deny your claim if the appropriate information is not submitted.

If a claim is based on the Education Benefit, proof of claim, provided at your authorized representative’s expense, must show:
- the date of enrollment of your qualified child in an accredited post-secondary institution of higher learning;
- the name of the institution;
- a list of courses for the current academic term; and
- the number of credit hours for the current academic term.

**WHEN CAN UNUM REQUEST AN AUTOPSY?**

In the case of death, Unum will have the right and opportunity to request an autopsy where not forbidden by law.

**HOW DO YOU DESIGNATE OR CHANGE A BENEFICIARY? (Beneficiary Designation)**

At the time you become insured, you should name a beneficiary on your enrollment form for your death benefits under your accidental death and dismemberment insurance. You may change your beneficiary at any time by filing a form approved by Unum with your Employer. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before your Employer receives that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, Unum has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If we are to make payments to a beneficiary who lacks the legal capacity to give us a release, Unum may pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This payment made in good faith satisfies Unum’s legal duty to the extent of that payment and Unum will not have to make payment again.

Also, at Unum’s option, we may pay up to $1,000 to the person or persons who, in our opinion, have incurred expenses for your last sickness and death.
HOW WILL UNUM MAKE PAYMENTS?

If your accidental death or dismemberment claim is at least $10,000 Unum will make available to you or your beneficiary a retained asset account (the Unum Security Account).

Payment for the accidental death or dismemberment claim may be accessed by writing a draft in a single sum or drafts in smaller sums. The funds for the draft or drafts are fully guaranteed by Unum.

If the accidental death or dismemberment claim is less than $10,000, Unum will pay it in one lump sum to you or your beneficiary.

Also, your beneficiary may request the accidental death claim to be paid according to one of Unum's other settlement options. This request must be in writing in order to be paid under Unum's other settlement options.

The Education Benefit will be paid to your qualified child or the qualified child’s legal representative.

All other benefits will be paid to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud; and
- any error Unum makes in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

WHAT ARE YOUR ASSIGNABILITY RIGHTS FOR THE DEATH BENEFITS UNDER YOUR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFITS? (Assignability Rights)

The rights provided to you by the plan(s) for accidental death insurance benefits are owned by you, unless:

- you have previously assigned these rights to someone else (known as an "assignee"); or
- you assign your rights under the plan(s) to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by you, and acceptable to us in form; and
- a signed or certified copy of the written assignment has been received and registered by us at our home office.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan(s’) provisions before receiving and registering an assignment.
GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are working for your Employer in an eligible group, the date you are eligible for coverage is the later of:

- the plan effective date; or
- the day after you complete your waiting period.

WHEN DOES YOUR COVERAGE BEGIN?

When your Employer pays 100% of the cost of your coverage under a plan, you will be covered at 12:01 a.m. on the later of:

- the date you are eligible for coverage; or
- the date Unum approves your evidence of insurability form, if evidence of insurability is required.

When you and your Employer share the cost of your coverage under a plan or when you pay 100% of the cost yourself, you will be covered at 12:01 a.m. on the latest of:

- the date you are eligible for coverage, if you apply for insurance on or before that date;
- the date you apply for insurance, if you apply within 31 days after your eligibility date; or
- the date Unum approves your evidence of insurability form, if evidence of insurability is required.

Evidence of insurability is required if you:

- are a late applicant, which means you apply for coverage more than 31 days after the date you are eligible for coverage; or
- voluntarily cancelled your coverage and are reapplying.

An evidence of insurability form can be obtained from your Employer.

WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?

If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to active employment.
ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE NOT WORKING DUE TO INJURY OR SICKNESS?

If you are not working due to injury or sickness, and if premium is paid, you may continue to be covered up to your retirement date.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?

If you are on a temporary layoff, and if premium is paid, you will be covered through the end of the month that immediately follows the month in which your temporary layoff begins.

If you are on a leave of absence, and if premium is paid, you will be covered through the end of the month that immediately follows the month in which your leave of absence begins.

WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?

Once your coverage begins, any increased or additional coverage due to a change in your annual earnings or due to a plan change requested by your Employer will take effect immediately or on the date Unum approves your evidence of insurability form, if evidence of insurability is required. You must be in active employment or on a covered layoff or leave of absence.

If you are not in active employment due to injury or sickness, any increased or additional coverage due to a change in your annual earnings or due to a plan change will begin on the date you return to active employment.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

WHEN DOES YOUR COVERAGE END?

Your coverage under the Summary of Benefits or a plan ends on the earliest of:

- the date the Summary of Benefits or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in this certificate of coverage.

Unum will provide coverage for a payable claim which occurs while you are covered under the Summary of Benefits or plan.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You or your authorized representative can start legal action regarding a claim 60 days after proof of claim has been given and up to 3 years from the time proof of claim is required, unless otherwise provided under federal law.
**HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?**

Unum considers any statements you or your Employer make in a signed application for coverage or an evidence of insurability form a representation and not a warranty. If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or  
- cancel your coverage from the original effective date.

We will use only statements made in a signed application or an evidence of insurability form as a basis for doing this.

Except in the case of fraud, Unum can take action only in the first 2 years coverage is in force.

If the Employer gives us information about you that is incorrect, we will:

- use the facts to decide whether you have coverage under the plan and in what amounts; and  
- make a fair adjustment of the premium.

**HOW WILL UNUM HANDLE INSURANCE FRAUD?**

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

**DOES THE SUMMARY OF BENEFITS REPLACE OR AFFECT ANY WORKERS’ COMPENSATION OR STATE DISABILITY INSURANCE?**

The Summary of Benefits does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

**DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM’S AGENT?**

For the purposes of the Summary of Benefits, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.
LIFE INSURANCE

BENEFIT INFORMATION

WHEN WILL YOUR BENEFICIARY RECEIVE PAYMENT?

Your beneficiary(ies) will receive payment when Unum approves your death claim.

WHAT DOCUMENTS ARE REQUIRED FOR PROOF OF DEATH?

Unum will require a certified copy of the death certificate, enrollment documents and a Notice and Proof of Claim form.

HOW MUCH WILL UNUM PAY YOUR BENEFICIARY IF UNUM APPROVES YOUR DEATH CLAIM?

Unum will determine the payment according to the amount of insurance shown in the LIFE INSURANCE "BENEFITS AT A GLANCE" page.

WHAT ARE YOUR ANNUAL EARNINGS?

"Annual Earnings" means your gross annual income from your Employer in effect just prior to the date of loss. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation or income received from sources other than your Employer.

WHAT WILL WE USE FOR ANNUAL EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?

If you become disabled while you are on a covered layoff or leave of absence, we will use your annual earnings from your Employer in effect just prior to the date your absence began.

WHAT HAPPENS TO YOUR LIFE INSURANCE COVERAGE IF YOU BECOME DISABLED?

Your life insurance coverage may be continued for a specific time and your life insurance premium will be waived if you qualify as described below.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO HAVE LIFE PREMIUMS WAIVED?

You must be disabled through your elimination period.

Your elimination period is 9 months.

WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER BEGIN?

Your life insurance premium waiver will begin when we approve your claim, if the elimination period has ended and you meet the following conditions. Your Employer may continue premium payments until Unum notifies your Employer of the date your life insurance premium waiver begins.
Your life insurance premium will be waived if you meet these conditions:

- you are less than 60 and insured under the plan.
- you become disabled and remain disabled during the elimination period.
- you meet the notice and proof of claim requirements for disability while your life insurance is in effect or within three months after it ends.
- your claim is approved by Unum.

After we approve your claim, Unum does not require further premium payments for you while you remain disabled according to the terms and provisions of the plan.

Your life insurance amount will not increase while your life insurance premiums are being waived. Your life insurance amount will reduce or cease at any time it would reduce or cease if you had not been disabled.

**WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER END?**

The life insurance premium waiver will automatically end if:

- you recover and you no longer are disabled;
- you fail to give us proper proof that you remain disabled;
- you refuse to have an examination by a physician chosen by Unum;
- you reach age 65; or
- premium has been waived for 12 months and you are considered to reside outside the United States. You will be considered to reside outside the United States when you have been outside the United States for a total period of 6 months or more during any 12 consecutive months for which premium has been waived.

**HOW DOES UNUM DEFINE DISABILITY?**

You are disabled when Unum determines that:

- during the elimination period, you are not working in any occupation due to your injury or sickness; and
- after the elimination period, due to the same injury or sickness, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by training, education or experience.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

We may require you to be examined by a physician, other medical practitioner or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to be interviewed by an authorized Unum Representative.

**APPLYING FOR LIFE INSURANCE PREMIUM WAIVER**

Ask your Employer for a life insurance premium waiver claim form.
The form has instructions on how to complete and where to send the claim.

**WHAT INSURANCE IS AVAILABLE WHILE YOU ARE SATISFYING THE DISABILITY REQUIREMENTS? (See Conversion Privilege)**

You may use this life conversion privilege when your life insurance terminates while you are satisfying the disability requirements. Please refer to the conversion privilege below. You are not eligible to apply for this life conversion if you return to work and, again, become covered under the plan.

If an individual life insurance policy is issued to you, any benefit for your death under this plan will be paid only if the individual policy is returned for surrender to Unum. Unum will refund all premiums paid for the individual policy.

The amount of your death benefit will be paid to your named beneficiary for the plan. If, however, you named a different beneficiary for the individual policy and the policy is returned to Unum for surrender, that different beneficiary will not be paid.

If you want to name a different beneficiary for this group plan, you must change your beneficiary as described in the Beneficiary Designation page of this group plan.

**WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)**

When coverage ends under the plan, you can convert your coverage to an individual life policy, without evidence of insurability. The maximum amount that you can convert is the amount you are insured for under the plan. You may convert a lower amount of life insurance.

You must apply for individual life insurance under this life conversion privilege and pay the first premium within 31 days after the date:

- your employment terminates; or
- you no longer are eligible to participate in the coverage of the plan.

If you convert to an individual life policy, then return to work, and, again, become insured under the plan, you are not eligible to convert to an individual life policy again. However, you do not need to surrender that individual life policy when you return to work.

Converted insurance may be of any type of the level premium whole life plans then in use by Unum. You may elect one year of Preliminary Term insurance under the level premium whole life policy. The individual policy will not contain disability or other extra benefits.

**WHAT LIMITED CONVERSION IS AVAILABLE IF THE SUMMARY OF BENEFITS OR THE PLAN IS CANCELLED? (Conversion Privilege)**

You may convert a limited amount of life insurance if you have been insured under your Employer’s group plan with Unum for at least five (5) years and the Summary of Benefits or the plan:

- is cancelled with Unum; or
- changes so that you no longer are eligible.
The individual life policy maximum will be the lesser of:

- $10,000; or
- your coverage amount under the plan less any amount that becomes available under any other group life plan offered by your Employer within 31 days after the date the Summary of Benefits or the plan is cancelled.

**PREMIUMS**

Premiums for the converted insurance will be based on:

- your then attained age on the effective date of the individual life policy;
- the type and amount of insurance to be converted;
- Unum’s customary rates in use at that time; and
- the class of risk to which you belong.

If the premium payment has been made, the individual life policy will be effective at the end of the 31 day conversion application period.

**DEATH DURING THE THIRTY-ONE DAY CONVERSION APPLICATION PERIOD**

If you die within the 31 day conversion application period, Unum will pay the beneficiary(ies) the amount of insurance that could have been converted. This coverage is available whether or not you have applied for an individual life policy under the conversion privilege.

**APPLYING FOR CONVERSION**

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit
2211 Congress Street
Portland, Maine 04122-1350
1-800-343-5406

**WILL UNUM ACCELERATE YOUR DEATH BENEFIT FOR THE PLAN IF YOU BECOME TERMINALLY ILL? (Accelerated Benefit)**

If you become terminally ill while you are insured by the plan, Unum will pay you a portion of your life insurance benefit one time. The payment will be based on 50% of your life insurance amount. However, the one-time benefit paid will not be greater than $750,000.

Your right to exercise this option and to receive payment is subject to the following:

- you request this election, in writing, on a form acceptable to Unum;
- you must be terminally ill at the time of payment of the Accelerated Benefit;
- your physician must certify, in writing, that you are terminally ill and your life expectancy has been reduced to less than 12 months; and
- the physician’s certification must be deemed satisfactory to Unum.
The Accelerated Benefit is available on a voluntary basis. Therefore, you are not eligible for benefits if:

- you are required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or
- you are required by a government agency to use this benefit in order to apply for, get, or otherwise keep a government benefit or entitlement.

Premium payments must continue to be paid on the full amount of life insurance unless you qualify to have your life premium waived.

If you have assigned your rights under the plan to an assignee or made an irrevocable beneficiary designation, Unum must receive consent, in writing, that the assignee or irrevocable beneficiary has agreed to the Accelerated Benefit payment on your behalf in a form acceptable to Unum before benefits are payable.

An election to receive an Accelerated Benefit will have the following effect on other benefits:

- the death benefit payable will be reduced by any amount of Accelerated Benefit that has been paid; and
- any amount of life insurance that would be continued under a disability continuation provision or that may be available under the conversion privilege will be reduced by the amount of the Accelerated Benefit paid. The remaining life insurance amount will be paid according to the terms of the Summary of Benefits subject to any reduction and termination provisions.

Benefits paid may be taxable. Unum is not responsible for any tax or other effects of any benefit paid. As with all tax matters, you should consult your personal tax advisor to assess the impact of this benefit.

**WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?**

Your plan does not cover any losses where death is caused by, contributed to by, or results from:

- suicide occurring within 24 months after your initial effective date of insurance; and
- suicide occurring within 24 months after the date any increases or additional insurance becomes effective for you.

The suicide exclusion will apply to any amounts of insurance for which you pay all or part of the premium.

The suicide exclusion also will apply to any amount that is subject to evidence of insurability requirements and Unum approves the evidence of insurability form and the amount you applied for at that time.
LIFE INSURANCE
OTHER BENEFIT FEATURES
WHAT COVERAGE IS AVAILABLE IF YOU END EMPLOYMENT OR YOU WORK REDUCED HOURS?  (Portability)

If your employment ends with or you retire from your Employer or you are working less than the minimum number of hours as described under Eligible Groups in this plan, you may elect portable coverage for yourself.

PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE

The portable insurance coverage will be the current coverage and amounts that you are insured for under your Employer's group plan.

However, the amount of portable coverage for you will not be more than:
- the highest amount of life insurance available for employees under the plan; or
- 5x your annual earnings; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The minimum amount of coverage that can be ported is $5,000. If the current amounts under the plan are less than $5,000, you may port the lesser amounts.

Your amount of life insurance will reduce or cease at any time it would reduce or cease for your eligible group if you had continued in active employment with your Employer.

APPLYING FOR PORTABLE COVERAGE

You must apply for portable coverage for yourself and pay the first premium within 31 days after the date:
- your coverage ends or you retire from your Employer; or
- you begin working less than the minimum number of hours as described under Eligible Groups in this plan.

You are not eligible to apply for portable coverage for yourself if:
- you have an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan.

If we determine that because of an injury or sickness, which has a material effect on life expectancy, you were not eligible for portability at the time you elected portable
coverage, the benefit will be adjusted to the amount of whole life coverage the premium would have purchased under the Conversion Privilege.

**APPLYING FOR INCREASES OR DECREASES IN PORTABLE COVERAGE**

You may increase or decrease the amount of life insurance coverage. The minimum and maximum benefit amounts are shown above. However, the amount of life insurance coverage cannot be decreased below $5,000. All increases are subject to evidence of insurability. Portable coverage will reduce at the ages and amounts shown in the LIFE INSURANCE "BENEFITS AT A GLANCE" page.

**WHEN PORTABLE COVERAGE ENDS**

Portable coverage for you will end for the following reasons:

- the date you fail to pay any required premium; or
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates).

If portable coverage ends due to failure to pay required premium, portable coverage cannot be reinstated.

**PREMIUM RATE CHANGES FOR PORTABLE COVERAGE**

Unum may change premium rates for portable coverage at any time for reasons which affect the risk assumed, including those reasons shown below:

- changes occur in the coverage levels;
- changes occur in the overall use of benefits by all insureds;
- changes occur in other risk factors; or
- a new law or a change in any existing law is enacted which applies to portable coverage.

The change in premium rates will be made on a class basis according to Unum's underwriting risk studies. Unum will notify the insured in writing at least 31 days before a premium rate is changed.

**APPLYING FOR CONVERSION, IF PORTABLE COVERAGE ENDS OR IS NOT AVAILABLE**

If you are not eligible to apply for portable coverage or portable coverage ends, then you may qualify for conversion coverage. Refer to Conversion Privilege under this plan.

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit
2211 Congress Street
Portland, Maine  04122-1350
1-800-343-5406
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

BENEFIT INFORMATION

WHEN WILL YOUR BENEFICIARY RECEIVE PAYMENT IN THE EVENT OF YOUR DEATH IF YOUR DEATH IS THE DIRECT RESULT OF AN ACCIDENT?

Your beneficiary(ies) will receive payment when Unum approves your death claim providing you meet certain conditions.

WHAT DOCUMENTS ARE REQUIRED FOR PROOF OF ACCIDENTAL DEATH?

Unum will require a certified copy of the death certificate, enrollment documents and a Notice and Proof of Claim form.

WHEN WILL YOU RECEIVE PAYMENT IN THE EVENT OF CERTAIN OTHER COVERED LOSSES IF THE LOSS IS THE DIRECT RESULT OF AN ACCIDENT?

You will receive payment when Unum approves the claim.

HOW MUCH WILL UNUM PAY YOUR BENEFICIARY IN THE EVENT OF YOUR ACCIDENTAL DEATH OR YOU FOR CERTAIN OTHER COVERED LOSSES?

If Unum approves the claim, Unum will determine the payment according to the Covered Losses and Benefits List below. The benefit Unum will pay is listed opposite the corresponding covered loss.

The benefit will be paid only if an accidental bodily injury results in one or more of the covered losses listed below within 365 days from the date of the accident.

Also, the accident must occur while you are insured under the plan.

<table>
<thead>
<tr>
<th>Covered Losses</th>
<th>Benefit Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>The Full Amount</td>
</tr>
<tr>
<td>Both Hands or Both Feet or Sight of Both Eyes</td>
<td>The Full Amount</td>
</tr>
<tr>
<td>One Hand and One Foot</td>
<td>The Full Amount</td>
</tr>
<tr>
<td>One Hand and Sight of One Eye</td>
<td>The Full Amount</td>
</tr>
<tr>
<td>One Foot and Sight of One Eye</td>
<td>The Full Amount</td>
</tr>
<tr>
<td>Speech and Hearing</td>
<td>The Full Amount</td>
</tr>
<tr>
<td>One Hand or One Foot</td>
<td>One Half The Full Amount</td>
</tr>
<tr>
<td>Sight of One Eye</td>
<td>One Half The Full Amount</td>
</tr>
</tbody>
</table>
Speech or Hearing
One Half The Full Amount

Thumb and Index
Finger of Same Hand
One Quarter The Full Amount

The most Unum will pay for any combination of Covered Losses from any one accident is the full amount.

The Full Amount is the amount shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE "BEFORE AT A GLANCE" page.

WHAT ARE YOUR ANNUAL EARNINGS?

"Annual Earnings" means your gross annual income from your Employer in effect just prior to the date of loss. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation or income received from sources other than your Employer.

WHAT WILL WE USE FOR ANNUAL EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?

If you have an accidental bodily injury that results in one or more of the covered losses while you are on a covered layoff or leave of absence, we will use your annual earnings from your Employer in effect just prior to the date your absence began.

WHAT REPATRIATION BENEFIT WILL UNUM PROVIDE?

Unum will pay an additional benefit for the preparation and transportation of your body to a mortuary chosen by you or your authorized representative. Payment will be made if, as the result of a covered accident, you suffer loss of life at least 100 miles away from your principal place of residence.

However, when combined with two or more Unum accidental death and dismemberment insurance plans, the combined overall maximum for these plans together cannot exceed the actual expenses for the preparation and transportation of your body to a mortuary.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE "BEFORE AT A GLANCE" page.

WHAT SEATBELT(S) AND AIR BAG BENEFIT WILL UNUM PROVIDE?

Unum will pay you or your authorized representative an additional benefit if you sustain an accidental bodily injury which causes your death while you are driving or riding in a Private Passenger Car, provided:

For Seatbelt(s):
- the Private Passenger Car is equipped with seatbelt(s); and
- the seatbelt(s) were in actual use and properly fastened at the time of the covered accident; and
- the position of the seatbelt(s) are certified in the official report of the covered accident, or by the investigating officer. A copy of the police accident report must be submitted with the claim.

Also, if such certification is not available, and it is clear that you were properly wearing seatbelt(s), then we will pay the additional seatbelt benefit.

However, if such certification is not available, and it is unclear whether you were properly wearing seatbelt(s), then we will pay a fixed benefit of $1,000.

An automatic harness seatbelt will not be considered properly fastened unless a lap belt is also used.

For Air Bag:
- the Private Passenger Car is equipped with an air bag for the seat in which you are seated; and
- the seatbelt(s) must be in actual use and properly fastened at the time of the covered accident.

No benefit will be paid if you are the driver of the Private Passenger Car and do not hold a current and valid driver's license.

No benefit will be paid if Unum is able to verify that the air bag(s) had been disengaged prior to the accident.

The accident causing your death must occur while you are insured under the plan.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT "BENEFITS AT A GLANCE" page.

**WHAT EDUCATION BENEFIT WILL UNUM PROVIDE FOR YOUR QUALIFIED CHILDREN?**

Unum will pay your authorized representative on behalf of each of your qualified children a lump sum payment if:

- you lose your life:
  • as a result of an accidental bodily injury; and
  • within 365 days after the date of the accident causing the accidental bodily injury;
- the accident causing your accidental bodily injury occurred while you were insured under the plan;
- proof is furnished to Unum that the child is a qualified child; and
- the qualified child continues to be enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level.

The benefit amount per academic year, maximum benefit payments, maximum benefit amount and maximum benefit period are shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE "BENEFITS AT A GLANCE" page.
WHEN WILL THE EDUCATION BENEFIT END FOR EACH QUALIFIED CHILD?

The education benefit will terminate for each qualified child on the earliest of the following dates:

- the date your qualified child fails to furnish proof as required by us;
- the date your qualified child no longer qualifies as a dependent child for any reason except your death; or
- the end of the maximum benefit period.

WHAT COVERAGE FOR EXPOSURE AND DISAPPEARANCE BENEFIT WILL UNUM PROVIDE?

Unum will pay a benefit if you sustain an accidental bodily injury and are unavoidably exposed to the elements and suffer a loss.

We will presume you suffered loss of life due to an accident if:
- you are riding in a common public passenger carrier that is involved in an accident covered under the Summary of Benefits; and
- as a result of the accident, the common public passenger carrier is wrecked, sinks, is stranded, or disappears; and
- your body is not found within 1 year of the accident.

Also, the accident must occur while you are insured under the plan.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT "BENEFITS AT A GLANCE" page.

WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any accidental losses caused by, contributed to by, or resulting from:

- suicide, self destruction while sane, intentionally self-inflicted injury while sane, or self-inflicted injury while insane.
- active participation in a riot.
- an attempt to commit or commission of a crime.
- the use of any prescription or non-prescription drug, poison, fume, or other chemical substance unless used according to the prescription or direction of your physician. This exclusion will not apply to you if the chemical substance is ethanol.
- disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders.
- being intoxicated.
- war, declared or undeclared, or any act of war.
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

OTHER BENEFIT FEATURES

WHAT COVERAGE IS AVAILABLE IF YOU END EMPLOYMENT OR YOU WORK REDUCED HOURS? (Portability)

If your employment ends with or you retire from your Employer or you are working less than the minimum number of hours as described under Eligible Groups in this plan, you may elect portable coverage for yourself.

PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE

The portable insurance coverage will be the current coverage and amounts that you are insured for under your Employer's group plan.

However, the amount of portable coverage for you will not be more than:

- the highest amount of accidental death and dismemberment insurance available for employees under the plan; or
- 5x your annual earnings; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The minimum amount of coverage that can be ported is $5,000. If the current amounts under the plan are less than $5,000, you may port the lesser amounts.

Your amount of AD&D insurance will reduce or cease at any time it would reduce or cease for your eligible group if you had continued in active employment with your Employer.

APPLYING FOR PORTABLE COVERAGE

You must apply for portable coverage for yourself and pay the first premium within 31 days after the date:

- your coverage ends or you retire from your Employer; or
- you begin working less than the minimum number of hours as described under Eligible Groups in this plan.

You are not eligible to apply for portable coverage for yourself if:

- you have an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan.
APPLYING FOR INCREASES OR DECREASES IN PORTABLE COVERAGE

You may increase or decrease the amount of AD&D insurance coverage. The minimum and maximum benefit amounts are shown above. However, the amount of accidental death and dismemberment insurance coverage cannot be decreased below $5,000. Portable coverage will reduce at the ages and amounts shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE "BENEFITS AT A GLANCE" page.

WHEN PORTABLE COVERAGE ENDS

Portable coverage for you will end for the following reasons:

- the date you fail to pay any required premium; or
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates).

If portable coverage ends due to failure to pay required premium, portable coverage cannot be reinstated.

PREMIUM RATE CHANGES FOR PORTABLE COVERAGE

Unum may change premium rates for portable coverage at any time for reasons which affect the risk assumed, including those reasons shown below:

- changes occur in the coverage levels;
- changes occur in the overall use of benefits by all insureds;
- changes occur in other risk factors; or
- a new law or a change in any existing law is enacted which applies to portable coverage.

The change in premium rates will be made on a class basis according to Unum's underwriting risk studies. Unum will notify the insured in writing at least 31 days before a premium rate is changed.
GLOSSARY

ACCIDENTAL BODILY INJURY means bodily harm caused solely by external, violent and accidental means and not contributed to by any other cause.

ACTIVE EMPLOYMENT means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under Eligible Group(s) in each plan.

Your work site must be:

- your Employer's usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment. Temporary and seasonal workers are excluded from coverage.

ANNUAL EARNINGS means your annual income received from your Employer as defined in the plan.

ELIMINATION PERIOD means a period of continuous disability which must be satisfied before you are eligible to have your life premium waived by Unum.

EMPLOYEE means a person who is in active employment in the United States with the Employer.

EMPLOYER means the Employer/Applicant named in the Application For Participation in the Select Group Insurance Trust, on the first page of the Summary of Benefits and in all amendments. It includes any division, subsidiary or affiliated company named in the Summary of Benefits.

EVIDENCE OF INSURABILITY means a statement of your medical history which Unum will use to determine if you are approved for coverage. Evidence of insurability will be at Unum's expense.

GAINFUL OCCUPATION means an occupation that within 12 months of your return to work is or can be expected to provide you with an income that is at least equal to 60% of your annual earnings in effect just prior to the date your disability began.

GRACE PERIOD means the period of time following the premium due date during which premium payment may be made.

HOSPITAL OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing your disability.

INJURY means:

- for purposes of Portability, a bodily injury that is the direct result of an accident and not related to any other cause.
- for all other purposes, a bodily injury that is the direct result of an accident and not related to any other cause. Disability must begin while you are covered under the plan.
INSURED means any person covered under a plan.

INTOXICATED means that your blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state where the accident occurred.

LAYOFF or LEAVE OF ABSENCE means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

LOSS OF A FOOT means that all of the foot is cut off at or above the ankle joint.

LOSS OF A HAND means that all four fingers are cut off at or above the knuckles joining each to the hand.

LOSS OF HEARING means the total and irrecoverable loss of hearing in both ears.

LOSS OF SIGHT means the eye is totally blind and that no sight can be restored in that eye.

LOSS OF SPEECH means the total and irrecoverable loss of speech.

LOSS OF THUMB AND INDEX FINGER means that all of the thumb and index finger are cut off at or above the joint closest to the wrist.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the Summary of Benefits.

PHYSICIAN means:
- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize you, or your spouse, children, parents or siblings as a physician for a claim that you send to us.

PLAN means a line of coverage under the Summary of Benefits.

PRIVATE PASSENGER CAR means a validly registered four-wheel private passenger car (including Employer-owned cars), station wagons, jeeps, pick-up trucks, and vans that are used only as private passenger cars.

QUALIFIED CHILD is any of your unmarried dependent children under age 25 who, on the date of your death as a result of an accidental bodily injury, was either:
enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level; or
- at the 12th grade level and enrolls as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level within 365 days following the date of your death.

Children include your own natural offspring, lawfully adopted children and stepchildren. They also include foster children and other children who are dependent on you for main support and living with you in a regular parent-child relationship. A child will be considered adopted on the date of placement in your home.

**REGULAR CARE** means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

**RETAINED ASSET ACCOUNT:**

- **for Life Insurance**, is an interest bearing account established through an intermediary bank in the name of your beneficiary, as owner.
- **for Accidental Death and Dismemberment Insurance**, is an interest bearing account established through an intermediary bank in the name of you or your beneficiary, as owner.

**SICKNESS** means:

- **for purposes of Portability**, an illness, disease or symptoms for which a person, in the exercise of ordinary prudence, would have consulted a health care provider.
- **for all other purposes**, an illness or disease. Disability must begin while you are covered under the plan.

**TRUST** means the policyholder trust named on the first page of the Summary of Benefits and all amendments to the policy.

**WAITING PERIOD** means the continuous period of time (shown in each plan) that you must be in active employment in an eligible group before you are eligible for coverage under a plan.


**YOU** means an employee who is eligible for Unum coverage.
ERISA

Additional Summary Plan Description Information

If this Summary of Benefits provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your certificate of coverage, constitute the summary plan description. The summary plan description and the Summary of Benefits constitute the Plan. Benefit determinations are controlled exclusively by the Summary of Benefits, your certificate of coverage and the information contained in this document.

Name of Plan:
Children's Friend and Service Plan

Name and Address of Employer:
Children's Friend and Service
153 Summer Street
Providence, Rhode Island
02903

Plan Identification Number:
a. Employer IRS Identification #: 05-0258819
b. Plan #: 501

Type of Welfare Plan:
Life and Accidental Death and Dismemberment

Type of Administration:
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance Summary of Benefits issued to the Plan.

ERISA Plan Year Ends:
December 31

Plan Administrator, Name, Address, and Telephone Number:
Children's Friend and Service
153 Summer Street
Providence, Rhode Island
02903
(401) 276-4300

Children's Friend and Service is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

Agent for Service of Legal Process on the Plan:
Children's Friend and Service
153 Summer Street
Providence, Rhode Island
02903
Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

**Funding and Contributions:**
The Plan is funded by insurance issued by Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122 (hereinafter referred to as "Unum") under identification number 395970 012. Contributions to the Plan are made as stated under "WHO PAYS FOR THE COVERAGE" in the Certificate of Coverage.

**EMPLOYER'S RIGHT TO AMEND THE PLAN**
The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of this Plan (including any related documents and underlying policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in writing and endorsed on or attached to the Plan.

**EMPLOYER'S RIGHT TO REQUEST SUMMARY OF BENEFITS CHANGE**
The Employer can request a Summary of Benefits change. Only an officer or registrar of Unum can approve a change. The change must be in writing and endorsed on or attached to the Summary of Benefits.

**MODIFYING OR CANCELLING THE SUMMARY OF BENEFITS OR A PLAN UNDER THE SUMMARY OF BENEFITS**
The Summary of Benefits or a plan under the Summary of Benefits can be cancelled:

- by Unum; or
- by the Employer.

Unum may cancel or modify the Summary of Benefits or a plan if:

- there is less than 100% participation of those eligible employees for an Employer paid plan; or
- there is less than 75% participation of those eligible employees who pay all or part of the premium for a plan; or
- the Employer does not promptly provide Unum with information that is reasonably required; or
- the Employer fails to perform any of its obligations that relate to this Summary of Benefits; or
- fewer than 10 employees are insured under a plan; or
- the premium is not paid in accordance with the provisions of the Summary of Benefits that specify whether the Employer, the employee, or both, pay the premiums; or
- the Employer does not promptly report to Unum the names of any employees who are added or deleted from the eligible group; or
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Employer and/or its employees; or
- the Employer fails to pay any premium within the 31 day grace period.

If Unum cancels or modifies the Summary of Benefits or a plan, for reasons other than the Employer's failure to pay premium, a written notice will be delivered to the Employer at least 31 days prior to the cancellation date or modification date. The Employer may cancel the Summary of Benefits or plan if the modifications are unacceptable.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify the Summary of Benefits or a plan automatically at the end of the grace period. The Employer is liable for premium for coverage during the grace period. The Employer must pay Unum all premium due for the full period each plan is in force.

The Employer may cancel the Summary of Benefits or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Employer and Unum agree, the Summary of Benefits or a plan can be cancelled on an earlier date. If Unum or the Employer cancels the Summary of Benefits or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If the Summary of Benefits or a plan is cancelled, the cancellation will not affect a payable claim.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

If a claim is based on death, a covered loss not based on disability or for the Education Benefit

In the event that your claim is denied, either in full or in part, Unum will notify you in writing within 90 days after your claim was filed. Under special circumstances, Unum is allowed an additional period of not more than 90 days (180 days in total) within which to notify you of its decision. If such an extension is required, you will receive a written notice from Unum indicating the reason for the delay and the date you may expect a final decision. Unum's notice of denial shall include:

- the specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;
- a description of any additional material or information necessary to complete the claim and why that material or information is necessary; and
- a description of the Plan's procedures and applicable time limits for appealing the determination, including a statement of your right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal.
Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

**If a claim is based on your disability**

Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which Unum expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;
- reference specific Plan provision(s) on which the determination is based;
- describe additional material or information necessary to complete the claim and why such information is necessary;
- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and
- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

**APPEAL PROCEDURES**

**If an appeal is based on death, a covered loss not based on disability or for the Education Benefit**

If you or your authorized representative appeal a denied claim, it must be submitted within 90 days after you receive Unum's notice of denial. You have the right to:

- submit a request for review, in writing, to Unum;
- upon request and free of charge, reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations; and
- submit written comments, documents, records and other information relating to the claim to Unum.

Unum will make a full and fair review of the claim and all new information submitted whether or not presented or available at the initial determination, and may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review shall be made not later than 60 days following receipt of the written request for review. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension and the date by which the Plan expects to make a decision. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you need to provide it to us. The 60-day extension of the appeal review period will begin after you have provided that information.

The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those Summary of Benefits' provisions upon which the final decision is based. It will also include a statement describing your access to documents and describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the determination.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

**If an appeal is based on your disability**

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.
The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;
- a reference to the specific Plan provision(s) on which the determination is based;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;
- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and
- the statement that "You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

YOUR RIGHTS UNDER ERISA

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
OTHER RIGHTS

Unum, for itself and as claims fiduciary for the Plan, is entitled to legal and equitable relief to enforce its right to recover any benefit overpayments caused by your receipt of deductible sources of income from a third party. This right of recovery is enforceable even if the amount you receive from the third party is less than the actual loss suffered by you but will not exceed the benefits paid you under the Summary of Benefits. You agree that Unum and the Plan have an equitable lien over such sources of income until any benefit overpayments have been recovered in full.

DISCRETIONARY ACTS

The Plan, acting through the Plan Administrator, delegates to Unum and its affiliate Unum Group discretionary authority to make benefit determinations under the Plan. Unum and Unum Group may act directly or through their employees and agents or further delegate their authority through contracts, letters or other documentation or procedures to other affiliates, persons or entities. Benefit determinations include determining eligibility for benefits and the amount of any benefits, resolving factual disputes, and interpreting and enforcing the provisions of the Plan. All benefit determinations must be reasonable and based on the terms of the Plan and the facts and circumstances of each claim.

Once you are deemed to have exhausted your appeal rights under the Plan, you have the right to seek court review under Section 502(a) of ERISA of any benefit determinations with which you disagree. The court will determine the standard of review it will apply in evaluating those decisions.
SUMMARY

COVERAGE, LIMITATIONS AND EXCLUSIONS UNDER
RHODE ISLAND LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT
("Act")

A resident of Rhode Island who purchases life insurance, annuities, long term care or accident and health insurance should know that an insurance company licensed in Rhode Island to write these types of insurance is a member of the Rhode Island Life and Health Insurance Guaranty Association ("Association"). The purpose of the Association is to assure that a policyholder will be protected within the statutory limits, if a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will, within the statutory limits, pay the claims of insured persons who live in this state, and, in some cases, keep coverage in force. However, the protection provided through the Association is not unlimited. This protection is not a substitute for your care in selecting a company that is well managed and financially stable.

LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION DISCLAIMER

The Rhode Island Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned on residence of in this state. Other conditions may also preclude coverage.

The Life and Health Insurance Guaranty Association will respond to any questions you may have which are not answered by this document. Your insurer and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy. You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association when selecting an insurer.

Rhode Island Life and Health Insurance Guaranty Association
235 Promenade Street, #426, Providence, RI 02908
Tel. (401) 273-2921

Rhode Island Division of Insurance
1511 Pontiac Avenue, Cranston, RI 02920
Tel. (401) 462-9520

The full text of the state law that provides for this safety-net coverage, Rhode Island Life and Health Insurance Guaranty Association Act, ("the Act"), can be found beginning at R.I. Gen. Laws §27-34.3-3. A brief summary of the Act is provided below. This summary does not cover all provisions of the law, nor does it in any way change your rights or obligations or those of the Association under the Act.

COVERAGE: Generally, individuals will be protected by the Association if the individual lives in Rhode Island and: Holds a life or health insurance contract, long term care
contract or annuity contract; or is insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live elsewhere.

EXCLUSIONS FROM COVERAGE: The Association does NOT protect a person holding a policy if:

- the individual is eligible for protection under a similar law of another state;
- the insurer was not authorized to do business in this state;
- the policy is issued by an organization that is not a member of the Association;
- the policy was issued by a nonprofit hospital or medical service organization (such as, the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments or by an insurance exchange.

The Association does NOT provide coverage for:

- a policy or portion of a policy not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- a policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed a rate specified by statute;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- an employer’s plan to the extent that it is self-funded (that is, not insured by an insurance company, even if an insurance company administers the plan);
- an unallocated annuity contract issued to an employee benefit plan protected under the United States Pension Benefit Guaranty Corporation;
- that part of an unallocated annuity contract not issued to a specific employee, union, association of natural persons benefit plan, or a government lottery;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the insurer;
- any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law;
- an obligation that does not arise under the express written terms of the policy or contract issued by the insurer.

- a policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code (commonly known as Medicare Part C & D) or any regulations issued pursuant thereto.
LIMITATIONS ON COVERAGE: The Act limits the amount the Association is obligated to pay. The Association cannot pay more than what the insurer would have owed under a policy or contract. Also, for any one insured life, no matter how many policies or contracts were in force with the same insurer, the Association will pay no more than:

- $300,000 in net life insurance death benefits and no more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

- $100,000 for health insurance benefits, coverages not defined as disability, basic hospital, medical, and surgical, major medical insurance, or long term care insurance including any net cash surrender and net cash withdrawal values;

- $300,000 for disability insurance;

- $300,000 for long term care insurance;

- $500,000 for basic hospital, medical, and surgical or major medical insurance;

- $250,000 in present value of annuity benefits, including net cash surrender and net cash withdrawal value;

- $250,000 in present value per payee with respect to a structured settlement annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;

- $250,000, in the aggregate, in present value of annuity benefits, including net cash surrender and net cash withdrawal values, with respect to an individual participating in a governmental retirement plan established under 26 U.S.C. §§401, 403(b), or 457 and covered by an unallocated annuity contract, or the beneficiaries of the each such individual if the individual is deceased;

- $5,000,000 in unallocated annuity contract benefits, irrespective of the number of contracts, with respect to the contract owner or plan sponsor whose plan owns, directly or in trust, one or more unallocated annuity contracts.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the Act: for unallocated annuities that fund government retirement plans under sections 401(k), 403(b), or 457 of the Internal Revenue Code, the limit is $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the Association be liable to spend more than $300,000 in the aggregate per individual except hospital insurance up to $500,000 per individual. For covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases the contract limits also apply.

These general statements as to Limitations on Coverage are only summaries of the law. The actual limitations are set forth in R.I. Gen. Laws §27-34.3-3.

All alleged violations of the provisions of the Rhode Island Life and Health Insurance Guaranty Association Act may be reported to the Rhode Island Division of Insurance at the address and telephone number above.
This information is provided by: The Association and by the Division of Insurance, whose respective addresses are provided in the Disclaimer, above.
Children's Friend and Service

Your Group Long Term Disability Plan

Policy No. 395970 011

Underwritten by Unum Life Insurance Company of America

1/22/2013
CERTIFICATE OF COVERAGE

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the policy (issued to the policyholder), the policy will govern. Your coverage may be cancelled or changed in whole or in part under the terms and provisions of the policy.

The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. When making a benefit determination under the policy, Unum has discretionary authority to determine your eligibility for benefits and to interpret the terms and provisions of the policy.

For purposes of effective dates and ending dates under the group policy, all days begin at 12:01 a.m. and end at 12:00 midnight at the Policyholder's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122
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BENEFITS AT A GLANCE

LONG TERM DISABILITY PLAN

This long term disability plan provides financial protection for you by paying a portion of your income while you are disabled. The amount you receive is based on the amount you earned before your disability began. In some cases, you can receive disability payments even if you work while you are disabled.

EMPLOYER’S ORIGINAL PLAN

EFFECTIVE DATE: January 1, 2013

POLICY NUMBER: 395970 011

ELIGIBLE GROUP(S):
All Full-Time Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:
Employees must be working at least 20 hours per week.

WAITING PERIOD:
For employees in an eligible group on or before January 1, 2013: None
For employees entering an eligible group after January 1, 2013: First of the month coincident with or next following the date you enter an eligible group

REHIRE:
If your employment ends and you are rehired within 12 months, your previous work while in an eligible group will apply toward the waiting period. All other policy provisions apply.

WHO PAYS FOR THE COVERAGE:
Your Employer pays the cost of your coverage.

ELIMINATION PERIOD:
180 days

Benefits begin the day after the elimination period is completed.

MONTHLY BENEFIT:
60% of monthly earnings to a maximum benefit of $5,000 per month.

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan.

MAXIMUM PERIOD OF PAYMENT:

<table>
<thead>
<tr>
<th>Age at Disability</th>
<th>Maximum Period of Payment</th>
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<tbody>
<tr>
<td>Less than Age 62</td>
<td>To Social Security Normal Retirement Age</td>
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<tr>
<td>Age 62</td>
<td>60 months</td>
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<td>Age 63</td>
<td>48 months</td>
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<td>Age 64</td>
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<td>Age 65</td>
<td>36 months</td>
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<td>Age 66</td>
<td>30 months</td>
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<td>Age 67</td>
<td>24 months</td>
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<td>Age 68</td>
<td>18 months</td>
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<td>Age 69 or older</td>
<td>12 months</td>
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<tr>
<td>Year of Birth</td>
<td>Social Security Normal Retirement Age</td>
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<tr>
<td>1937 or before</td>
<td>65 years</td>
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<td>1938</td>
<td>65 years 2 months</td>
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<td>1939</td>
<td>65 years 4 months</td>
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<td>1940</td>
<td>65 years 6 months</td>
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<td>1941</td>
<td>65 years 8 months</td>
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<td>1942</td>
<td>65 years 10 months</td>
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<td>1943-1954</td>
<td>66 years</td>
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<td>1955</td>
<td>66 years 2 months</td>
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<td>1956</td>
<td>66 years 4 months</td>
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<td>1957</td>
<td>66 years 6 months</td>
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<td>1958</td>
<td>66 years 8 months</td>
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<tr>
<td>1959</td>
<td>66 years 10 months</td>
</tr>
<tr>
<td>1960 and after</td>
<td>67 years</td>
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</tbody>
</table>

No premium payments are required for your coverage while you are receiving payments under this plan.

**REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFIT:**

10% of your gross disability payment to a maximum benefit of $1,000 per month.

In addition, we will make monthly payments to you for 3 months following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

**DEPENDENT CARE EXPENSE BENEFIT:**

While you are participating in Unum’s Rehabilitation and Return to Work Assistance program, you may receive payments to cover certain dependent care expenses limited to the following amounts:

- **Dependent Care Expense Benefit Amount:** $350 per month, per dependent
- **Dependent Care Expense Maximum Benefit Amount:** $1,000 per month for all eligible dependent care expenses combined

**TOTAL BENEFIT CAP:**

The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings. However, if you are participating in Unum’s Rehabilitation and Return to Work Assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110% of your monthly earnings.

**OTHER FEATURES:**

- Continuity of Coverage
- Minimum Benefit
- Pre-Existing: 3/12
- Survivor Benefit
- Work Life Assistance Program

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.

The plan includes enrollment, risk management and other support services related to your Employer’s Benefit Program.
CLAIM INFORMATION
LONG TERM DISABILITY

WHEN DO YOU NOTIFY UNUM OF A CLAIM?

We encourage you to notify us of your claim as soon as possible so that a claim decision can be made in a timely manner. Notice of claim should be sent within 30 days after the date your disability begins. In addition, you must send Unum proof of your claim no later than one year after the date your disability begins unless your failure to do so is due to your lack of legal capacity. In no event can proof of your claim be submitted after the expiration of the time limit for commencing a legal proceeding as stated in the policy, even if your failure to provide proof of claim is due to a lack of legal capacity or if state law provides an exception to the one year time period.

You must notify us immediately when you return to work in any capacity.

HOW DO YOU FILE PROOF OF CLAIM?

You and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

The form to use to submit your proof of claim is available from your Employer, or you can request the form from us. If you do not receive the form from Unum or your Employer within 15 days of your request, send Unum proof of claim without waiting for the form.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

Proof of your claim, provided at your expense, must show:

- the date your disability began;
- the existence and cause of your sickness or injury;
- that your sickness or injury causes you to have limitations on your functioning and restrictions on your activities preventing you from performing the material and substantial duties of your regular occupation or of any other gainful occupation for which you are reasonably fitted by education, training, or experience;
- that you are under the regular care of a physician;
- the name and address of any hospital or institution where you received treatment, including all attending physicians; and
- the appropriate documentation of your monthly earnings, any disability earnings, and any deductible sources of income.

In some cases, you will be required to give Unum authorization to obtain additional medical information and to provide non-medical information as part of your proof of claim, or proof of continuing disability. We may also require that you send us appropriate financial records, which may include income tax returns, which we believe are necessary to substantiate your income. We may request that you send periodic proof of your claim. This proof, provided at your expense, must be received within 45 days of a request by us. Unum will deny your claim, or stop sending you payments, if the appropriate information is not submitted.
We may require you to be examined by a physician, other medical practitioner and/or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to meet with and be interviewed by an authorized Unum Representative. Unum will deny your claim, or stop sending you payments, if you fail to comply with our requests.

**TO WHOM WILL UNUM MAKE PAYMENTS?**

Unum will make payments to you.

**WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?**

Unum has the right to recover any overpayments due to:

- fraud;
- any error Unum makes in processing a claim;
- disability earnings; or
- deductible sources of income.

You must reimburse us in full. We will determine the method by which the repayment is to be made which may include reducing or withholding future payments including the minimum monthly payment.

Unum will not recover more money than the amount we paid you.

Any unpaid premium due for your coverage under this policy may be recovered by us by offsetting against amounts otherwise payable to you under this policy, or by other legally permitted means.
GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are working for your Employer in an eligible group, the date you are eligible for coverage is the later of:

- the plan effective date; or
- the day after you complete your waiting period.

WHEN DOES YOUR COVERAGE BEGIN?

When your Employer pays 100% of the cost of your coverage under a plan, you will be covered at 12:01 a.m. on the date you are eligible for coverage.

When you and your Employer share the cost of your coverage under a plan or when you pay 100% of the cost yourself, you will be covered at 12:01 a.m. on the latest of:

- the date you are eligible for coverage, if you apply for insurance on or before that date;
- the date you apply for insurance, if you apply within 31 days after your eligibility date; or
- the date Unum approves your application, if evidence of insurability is required.

Evidence of insurability is required if you:

- are a late applicant, which means you apply for coverage more than 31 days after the date you are eligible for coverage; or
- voluntarily cancelled your coverage and are reapplying.

An evidence of insurability form can be obtained from your Employer.

WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?

If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to active employment.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?

If you are on a temporary layoff, and if premium is paid, you will be covered through the end of the month that immediately follows the month in which your temporary layoff begins.
If you are on a **leave of absence**, and if premium is paid, you will be covered through the end of the month that immediately follows the month in which your leave of absence begins.

**WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?**

Once your coverage begins, any increased or additional coverage will take effect immediately if you are in active employment or if you are on a covered layoff or leave of absence. If you are not in active employment due to injury or sickness, any increased or additional coverage will begin on the date you return to active employment.

Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the decrease.

**WHEN DOES YOUR COVERAGE END?**

Your coverage under the policy or a plan ends on the earliest of:

- the date the policy or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment except as provided under the covered layoff or leave of absence provision.

Unum will provide coverage for a payable claim which occurs while you are covered under the policy or plan.

**WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?**

You can start legal action regarding your claim 60 days after proof of claim has been given and up to 3 years from the later of when original proof of your claim was first required to have been given; or your claim was denied; or your benefits were terminated, unless otherwise provided under federal law.

**HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?**

Unum considers any statements you or your Employer make in a signed application for coverage a representation and not a warranty. If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

We will use only statements made in a signed application as a basis for doing this.

If the Employer gives us information about you that is incorrect, we will:

- use the facts to decide whether you have coverage under the plan and in what amounts; and
- make a fair adjustment of the premium.
**HOW WILL UNUM HANDLE INSURANCE FRAUD?**

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

**DOES THE POLICY REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?**

The policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

**DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?**

For purposes of the policy, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.
LONG TERM DISABILITY

BENEFIT INFORMATION

HOW DOES UNUM DEFINE DISABILITY?

You are disabled when Unum determines that:

- you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and
- you have a 20% or more loss in your indexed monthly earnings due to the same sickness or injury.

After 24 months of payments, you are disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO RECEIVE BENEFITS?

You must be continuously disabled through your elimination period. Unum will treat your disability as continuous if your disability stops for 30 days or less during the elimination period. The days that you are not disabled will not count toward your elimination period.

Your elimination period is 180 days.

You are not required to have a 20% or more loss in your indexed monthly earnings due to the same injury or sickness to be considered disabled during the elimination period.

CAN YOU SATISFY YOUR ELIMINATION PERIOD IF YOU ARE WORKING?

Yes. If you are working while you are disabled, the days you are disabled will count toward your elimination period.

WHEN WILL YOU BEGIN TO RECEIVE PAYMENTS?

You will begin to receive payments when we approve your claim, providing the elimination period has been met and you are disabled. We will send you a payment monthly for any period for which Unum is liable.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED?

We will follow this process to figure your payment:
1. Multiply your monthly earnings by 60%.
2. The maximum monthly benefit is $5,000.
3. Compare the answer from Item 1 with the maximum monthly benefit. The lesser of these two amounts is your gross disability payment.
4. Subtract from your gross disability payment any deductible sources of income.

The amount figured in Item 4 is your monthly payment.

Your monthly payment may be reduced based on your disability earnings.

If, at any time after the elimination period, you are disabled for less than 1 month, we will send you 1/30 of your monthly payment for each day of disability and 1/30 of any additional benefits for each day of disability.

**WILL UNUM EVER PAY MORE THAN 100% OF MONTHLY EARNINGS?**

The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings. However, if you are participating in Unum’s Rehabilitation and Return to Work Assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110% of your monthly earnings.

**WHAT ARE YOUR MONTHLY EARNINGS?**

"Monthly Earnings" means your gross monthly income from your Employer in effect just prior to your date of disability. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than your Employer.

**WHAT WILL WE USE FOR MONTHLY EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?**

If you become disabled while you are on a covered layoff or leave of absence, we will use your monthly earnings from your Employer in effect just prior to the date your absence begins.

**HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED AND WORKING?**

We will send you the monthly payment if you are disabled and your monthly disability earnings, if any, are less than 20% of your indexed monthly earnings, due to the same sickness or injury.

If you are disabled and your monthly disability earnings are from 20% through 80% of your indexed monthly earnings, due to the same sickness or injury, Unum will figure your payment as follows:

During the first 12 months of payments, while working, your monthly payment will not be reduced as long as disability earnings plus the gross disability payment does not exceed 100% of indexed monthly earnings.

1. Add your monthly disability earnings to your gross disability payment.
2. Compare the answer in Item 1 to your indexed monthly earnings.
If the answer from Item 1 is less than or equal to 100% of your indexed monthly earnings, Unum will not further reduce your monthly payment.

If the answer from Item 1 is more than 100% of your indexed monthly earnings, Unum will subtract the amount over 100% from your monthly payment.

After 12 months of payments, while working, you will receive payments based on the percentage of income you are losing due to your disability.

1. Subtract your disability earnings from your indexed monthly earnings.
2. Divide the answer in Item 1 by your indexed monthly earnings. This is your percentage of lost earnings.
3. Multiply your monthly payment by the answer in Item 2.

This is the amount Unum will pay you each month.

As part of your proof of disability earnings, we can require that you send us appropriate financial records, which may include income tax returns, which we believe are necessary to substantiate your income.

After the elimination period, if you are disabled for less than 1 month, we will send you 1/30 of your payment for each day of disability.

HOW DO WE PROTECT YOU IF YOUR DISABILITY EARNINGS FLUCTUATE?

If your disability earnings have fluctuated from month to month, Unum may determine your benefit eligibility based on the average of your disability earnings over the most recent 3 months.

WHAT ARE DEDUCTIBLE SOURCES OF INCOME?

Unum will subtract from your gross disability payment the following deductible sources of income:

1. The amount that you receive or are entitled to receive under:
   - a workers' compensation law.
   - an occupational disease law.
   - any other act or law with similar intent.

2. The amount that you receive or are entitled to receive as disability income or disability retirement payments under any:
   - state compulsory benefit act or law.
   - other group insurance plan.
   - governmental retirement system.

3. The amount that you, your spouse and your children receive or are entitled to receive as disability payments because of your disability under:
   - the United States Social Security Act.
   - the Canada Pension Plan.
   - the Quebec Pension Plan.
- any similar plan or act.

4. The amount that you receive as retirement payments or the amount your spouse and children receive as retirement payments because you are receiving retirement payments under:

- the United States Social Security Act.
- the Canada Pension Plan.
- the Quebec Pension Plan.
- any similar plan or act.

5. The amount that you receive as retirement payments under any governmental retirement system. Retirement payments do not include payments made at the later of age 62 or normal retirement age under your Employer's retirement plan which are attributable to contributions you made on a post tax basis to the system.

Regardless of how retirement payments are distributed, Unum will consider payments attributable to your post tax contributions to be distributed throughout your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

6. The amount that you:

- receive as disability payments under your Employer's retirement plan.
- voluntarily elect to receive as retirement payments under your Employer's retirement plan.
- receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined in your Employer's retirement plan.

Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

Retirement payments will be those benefits which are based on your Employer's contribution to the retirement plan. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

Regardless of how the retirement funds from the retirement plan are distributed, Unum will consider your and your Employer's contributions to be distributed simultaneously throughout your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

7. The amount that you receive under Title 46, United States Code Section 688 (The Jones Act).
With the exception of retirement payments, Unum will only subtract deductible sources of income which are payable as a result of the same disability.

We will not reduce your payment by your Social Security retirement income if your disability begins after age 65 and you were already receiving Social Security retirement payments.

**WHAT ARE NOT DEDUCTIBLE SOURCES OF INCOME?**

Unum will not subtract from your gross disability payment income you receive from, but not limited to, the following:

- 401(k) plans
- profit sharing plans
- thrift plans
- tax sheltered annuities
- stock ownership plans
- non-qualified plans of deferred compensation
- pension plans for partners
- military pension and disability income plans
- credit disability insurance
- franchise disability income plans
- a retirement plan from another Employer
- individual retirement accounts (IRA)
- individual disability income plans
- no fault motor vehicle plans
- **salary continuation or accumulated sick leave** plans

**WHAT IF SUBTRACTING DEDUCTIBLE SOURCES OF INCOME RESULTS IN A ZERO BENEFIT? (Minimum Benefit)**

The minimum monthly payment is the greater of:

- $100; or
- 10% of your gross disability payment.

Unum may apply this amount toward an outstanding overpayment.

**WHAT HAPPENS WHEN YOU RECEIVE A COST OF LIVING INCREASE FROM DEDUCTIBLE SOURCES OF INCOME?**

Once Unum has subtracted any deductible source of income from your gross disability payment, Unum will not further reduce your payment due to a cost of living increase from that source.

**WHAT IF UNUM DETERMINES YOU MAY QUALIFY FOR DEDUCTIBLE INCOME BENEFITS?**

When we determine that you may qualify for benefits under Item(s) 1, 2 and 3 in the deductible sources of income section, we will estimate your entitlement to these benefits. We can reduce your payment by the estimated amounts if such benefits:

- have not been awarded; and
- have not been denied; or
- have been denied and the denial is being appealed.

Your Long Term Disability payment will NOT be reduced by the estimated amount if you:

- apply for the disability payments under Item(s) 1, 2 and 3 in the deductible sources of income section and appeal your denial to all administrative levels Unum feels are necessary; and
- sign Unum's payment option form. This form states that you promise to pay us any overpayment caused by an award.

If your payment has been reduced by an estimated amount, your payment will be adjusted when we receive proof:

- of the amount awarded; or
- that benefits have been denied and all appeals Unum feels are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to you.

If you receive a lump sum payment from any deductible sources of income, the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, we will use a reasonable one.

**HOW LONG WILL UNUM CONTINUE TO SEND YOU PAYMENTS?**

Unum will send you a payment each month up to the **maximum period of payment**. Your maximum period of payment is based on your age at disability as follows:

<table>
<thead>
<tr>
<th>Age at Disability</th>
<th>Maximum Period of Payment</th>
</tr>
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<tbody>
<tr>
<td>Less than Age 62</td>
<td>To Social Security Normal Retirement Age</td>
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<tr>
<td>Age 62</td>
<td>60 months</td>
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<td>Age 63</td>
<td>48 months</td>
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<td>Age 64</td>
<td>42 months</td>
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<td>Age 65</td>
<td>36 months</td>
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<td>Age 66</td>
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<td>Age 67</td>
<td>24 months</td>
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<td>Age 68</td>
<td>18 months</td>
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<tr>
<td>Age 69 or older</td>
<td>12 months</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Year of Birth</th>
<th>Social Security Normal Retirement Age</th>
</tr>
</thead>
<tbody>
<tr>
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<td>65 years</td>
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<tr>
<td>1938</td>
<td>65 years 2 months</td>
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<td>1939</td>
<td>65 years 4 months</td>
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<td>1957</td>
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<td>1958</td>
<td>66 years 8 months</td>
</tr>
<tr>
<td>1959</td>
<td>66 years 10 months</td>
</tr>
</tbody>
</table>
WHEN WILL PAYMENTS STOP?

We will stop sending you payments and your claim will end on the earliest of the following:

- during the first 24 months of payments, when you are able to work in your regular occupation on a **part-time basis** and you do not;
- after 24 months of payments, when you are able to work in any gainful occupation on a part-time basis and you do not;
- if you are working and your monthly disability earnings exceed 80% of your indexed monthly earnings, the date your earnings exceed 80%;
- the end of the maximum period of payment;
- the date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under Unum's Rehabilitation and Return to Work Assistance program;
- the date you fail to submit proof of continuing disability;
- after 12 months of payments if you are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits;
- the date you die.

WHAT DISABILITIES HAVE A LIMITED PAY PERIOD UNDER YOUR PLAN?

The lifetime cumulative maximum benefit period for all disabilities due to **mental illness** and disabilities based primarily on **self-reported symptoms** is 24 months. Only 24 months of benefits will be paid for any combination of such disabilities even if the disabilities:

- are not continuous; and/or
- are not related.

However, Unum will send you payments beyond the 24 month period if you meet one of these conditions:

1. If you are confined to a **hospital or institution** at the end of the 24 month period, Unum will continue to send you payments during your confinement.
   
   If you are still disabled when you are discharged, Unum will send you payments for a recovery period of up to 90 days.
   
   If you become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, Unum will send payments during that additional confinement and for one additional recovery period up to 90 more days.

2. If you are not confined to a hospital or institution but become confined for a period of at least 14 days within 90 days after the 24 month period for which you have received payments, Unum will send payments during the length of the confinement.
Under no circumstances will Unum pay beyond the maximum period of payment as indicated in the **BENEFITS AT A GLANCE** section of your policy.

Unum will not apply the mental illness limitation to dementia if it is a result of:

- stroke;
- trauma;
- viral infection;
- Alzheimer's disease; or
- other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

**WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?**

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- intentionally self-inflicted injuries.
- active participation in a riot.
- loss of a professional license, occupational license or certification.
- commission of a crime for which you have been convicted.
- pre-existing condition.

Your plan will not cover a disability due to war, declared or undeclared, or any act of war.

Unum will not pay a benefit for any period of disability during which you are incarcerated.

**WHAT IS A PRE-EXISTING CONDITION?**

You have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; and
- the disability begins in the first 12 months after your effective date of coverage.

**WHAT HAPPENS IF YOU RETURN TO WORK FULL TIME WITH THE POLICYHOLDER AND YOUR DISABILITY OCCURS AGAIN?**

If you have a recurrent disability, Unum will treat your disability as part of your prior claim and you will not have to complete another elimination period if:

- you were continuously insured under the plan for the period between the end of your prior claim and your recurrent disability; and
- your recurrent disability occurs within 6 months from the end of your prior claim.

Your recurrent disability will be subject to the same terms of the plan as your prior claim and will be treated as a continuation of that disability.
Any disability which occurs after 6 months from the date your prior claim ended will be treated as a new claim. The new claim will be subject to all of the policy provisions, including the elimination period.

If you become entitled to payments under any other group long term disability plan, you will not be eligible for payments under the Unum plan.
LONG TERM DISABILITY

OTHER BENEFIT FEATURES

WHAT BENEFITS WILL BE PROVIDED TO YOU OR YOUR FAMILY IF YOU DIE OR ARE TERMINALLY ILL? (Survivor Benefit)

When Unum receives proof that you have died, we will pay your eligible survivor a lump sum benefit equal to 3 months of your gross disability payment if, on the date of your death:

- your disability had continued for 180 or more consecutive days; and
- you were receiving or were entitled to receive payments under the plan.

If you have no eligible survivors, payment will be made to your estate, unless there is none. In this case, no payment will be made.

However, we will first apply the survivor benefit to any overpayment which may exist on your claim.

You may receive your 3 month survivor benefit prior to your death if you have been diagnosed as terminally ill.

We will pay you a lump sum amount equal to 3 months of your gross disability payment if:

- you have been diagnosed with a terminal illness or condition;
- your life expectancy has been reduced to less than 12 months; and
- you are receiving monthly payments.

Your right to exercise this option and receive payment is subject to the following:

- you must make this election in writing to Unum; and
- your physician must certify in writing that you have a terminal illness or condition and your life expectancy has been reduced to less than 12 months.

This benefit is available to you on a voluntary basis and will only be payable once.

If you elect to receive this benefit prior to your death, no 3 month survivor benefit will be payable upon your death.

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM? (Continuity of Coverage)

When the plan becomes effective, Unum will provide coverage for you if:

- you are not in active employment because of a sickness or injury; and
- you were covered by the prior policy.

Your coverage is subject to payment of premium.

Your payment will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which your prior carrier is liable.
WHAT IF YOU HAVE A DISABILITY DUE TO A PRE-EXISTING CONDITION WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM? (Continuity of Coverage)

Unum may send a payment if your disability results from a pre-existing condition if you were:

- in active employment and insured under the plan on its effective date; and
- insured by the prior policy at the time of change.

In order to receive a payment you must satisfy the pre-existing condition provision under:

1. the Unum plan; or
2. the prior carrier's plan, if benefits would have been paid had that policy remained in force.

If you do not satisfy Item 1 or 2 above, Unum will not make any payments.

If you satisfy Item 1, we will determine your payments according to the Unum plan provisions.

If you only satisfy Item 2, we will administer your claim according to the Unum plan provisions. However, your payment will be the lesser of:

a. the monthly benefit that would have been payable under the terms of the prior plan if it had remained in force; or
b. the monthly payment under the Unum plan.

Your benefits will end on the earlier of the following dates:

1. the end of the maximum benefit period under the plan; or
2. the date benefits would have ended under the prior plan if it had remained in force.

HOW CAN UNUM'S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM HELP YOU RETURN TO WORK?

Unum has a vocational Rehabilitation and Return to Work Assistance program available to assist you in returning to work. We will determine whether you are eligible for this program, at our sole discretion. In order to be eligible for rehabilitation services and benefits, you must be medically able to engage in a return to work program.

Your claim file will be reviewed by one of Unum's rehabilitation professionals to determine if a rehabilitation program might help you return to gainful employment. As your file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work program.

We will make the final determination of your eligibility for participation in the program.
We will provide you with a written Rehabilitation and Return to Work Assistance plan developed specifically for you.

The rehabilitation program may include at our sole discretion, but is not limited to, the following services and benefits:

- coordination with your Employer to assist you to return to work;
- adaptive equipment or job accommodations to allow you to work;
- vocational evaluation to determine how your disability may impact your employment options;
- job placement services;
- resume preparation;
- job seeking skills training; or
- education and retraining expenses for a new occupation.

**WHAT ADDITIONAL BENEFITS WILL UNUM PAY WHILE YOU PARTICIPATE IN A REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?**

We will pay an additional disability benefit of 10% of your gross disability payment to a maximum benefit of $1,000 per month.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income. However, the Total Benefit Cap will apply.

In addition, we will make monthly payments to you for 3 months following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

This benefit payment may be paid in a lump sum.

**WHEN WILL REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFITS END?**

Benefits for the Rehabilitation and Return to Work Assistance program will end on the earliest of the following dates:

- the date Unum determines that you are no longer eligible to participate in Unum’s Rehabilitation and Return to Work Assistance program; or
- any other date on which monthly payments would stop in accordance with this plan.

**WHAT ADDITIONAL BENEFIT IS AVAILABLE FOR DEPENDENT CARE EXPENSES TO ENABLE YOU TO PARTICIPATE IN UNUM’S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?**

While you are participating in Unum’s Rehabilitation and Return to Work Assistance program, we will pay a Dependent Care Expense Benefit when you are disabled and you:

1. are incurring expenses to provide care for a child under the age of 15; and/or
2. start incurring expenses to provide care for a child age 15 or older or a family member who needs personal care assistance.

The payment of the Dependent Care Expense Benefit will begin immediately after you start Unum's Rehabilitation and Return to Work Assistance program.

Our payment of the Dependent Care Expense Benefit will:

1. be $350 per month, per dependent; and
2. not exceed $1,000 per month for all dependent care expenses combined.

To receive this benefit, you must provide satisfactory proof that you are incurring expenses that entitle you to the Dependent Care Expense Benefit.

Dependent Care Expense Benefits will end on the earlier of the following:

1. the date you are no longer incurring expenses for your dependent;
2. the date you no longer participate in Unum’s Rehabilitation and Return to Work Assistance program; or
3. any other date payments would stop in accordance with this plan.
OTHER SERVICES

These services are also available from us as part of your Unum Long Term Disability plan.

IS THERE A WORK LIFE ASSISTANCE PROGRAM AVAILABLE WITH THE PLAN?

We do provide you and your dependents access to a work life assistance program designed to assist you with problems of daily living.

You can call and request assistance for virtually any personal or professional issue, from helping find a day care or transportation for an elderly parent, to researching possible colleges for a child, to helping to deal with the stress of the workplace. This work life program is available for everyday issues as well as crisis support.

This service is also available to your Employer.

This program can be accessed by a 1-800 telephone number available 24 hours a day, 7 days a week or online through a website.

Information about this program can be obtained through your plan administrator.

HOW CAN UNUM HELP YOUR EMPLOYER IDENTIFY AND PROVIDE WORKSITE MODIFICATION?

A worksite modification might be what is needed to allow you to perform the material and substantial duties of your regular occupation with your Employer. One of our designated professionals will assist you and your Employer to identify a modification we agree is likely to help you remain at work or return to work. This agreement will be in writing and must be signed by you, your Employer and Unum.

When this occurs, Unum will reimburse your Employer for the cost of the modification, up to the greater of:

- $1,000; or
- the equivalent of 2 months of your monthly benefit.

This benefit is available to you on a one time only basis.

HOW CAN UNUM’S SOCIAL SECURITY CLAIMANT ADVOCACY PROGRAM ASSIST YOU WITH OBTAINING SOCIAL SECURITY DISABILITY BENEFITS?

In order to be eligible for assistance from Unum’s Social Security claimant advocacy program, you must be receiving monthly payments from us. Unum can provide expert advice regarding your claim and assist you with your application or appeal.

Receiving Social Security benefits may enable:

- you to receive Medicare after 24 months of disability payments;
- you to protect your retirement benefits; and
- your family to be eligible for Social Security benefits.

We can assist you in obtaining Social Security disability benefits by:
- helping you find appropriate legal representation;
- obtaining medical and vocational evidence; and
- reimbursing pre-approved case management expenses.
ACTIVE EMPLOYMENT means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under Eligible Group(s) in each plan.

Your work site must be:

- your Employer's usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment. Temporary and seasonal workers are excluded from coverage.

DEDUCTIBLE SOURCES OF INCOME means income from deductible sources listed in the plan which you receive or are entitled to receive while you are disabled. This income will be subtracted from your gross disability payment.

DEPENDENT means:

- your child(ren) under the age of 15; and
- your child(ren) age 15 or over or a family member who requires personal care assistance.

DISABILITY EARNINGS means the earnings which you receive while you are disabled and working, plus the earnings you could receive if you were working to your maximum capacity.

ELIMINATION PERIOD means a period of continuous disability which must be satisfied before you are eligible to receive benefits from Unum.

EMPLOYEE means a person who is in active employment in the United States with the Employer.

EMPLOYER means the Policyholder, and includes any division, subsidiary or affiliated company named in the policy.

EVIDENCE OF INSURABILITY means a statement of your medical history which Unum will use to determine if you are approved for coverage. Evidence of insurability will be at Unum's expense.

GAINFUL OCCUPATION means an occupation that is or can be expected to provide you with an income within 12 months of your return to work, that exceeds:

80% of your indexed monthly earnings, if you are working; or
60% of your indexed monthly earnings, if you are not working.

GOVERNMENTAL RETIREMENT SYSTEM means a plan which is part of any federal, state, county, municipal or association retirement system, including but not limited to, a state teachers retirement system, public employees retirement system or other similar retirement system for state or local government employees providing for the payment of retirement and/or disability benefits to individuals.
**GRACE PERIOD** means the period of time following the premium due date during which premium payment may be made.

**GROSS DISABILITY PAYMENT** means the benefit amount before Unum subtracts deductible sources of income and disability earnings.

**HOSPITAL OR INSTITUTION** means an accredited facility licensed to provide care and treatment for the condition causing your disability.

**INDEXED MONTHLY EARNINGS** means your monthly earnings adjusted on each anniversary of benefit payments by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. Your indexed monthly earnings may increase or remain the same, but will never decrease.

The Consumer Price Index (CPI-U) is published by the U.S. Department of Labor. Unum reserves the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-U.

Indexing is only used as a factor in the determination of the percentage of lost earnings while you are disabled and working and in the determination of gainful occupation.

**INJURY** means a bodily injury that is the direct result of an accident and not related to any other cause. Disability must begin while you are covered under the plan.

**INSURED** means any person covered under a plan.

**LAW, PLAN OR ACT** means the original enactments of the law, plan or act and all amendments.

**LAYOFF** or **LEAVE OF ABSENCE** means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

**LIMITED** means what you cannot or are unable to do.

**MATERIAL AND SUBSTANTIAL DUTIES** means duties that:

- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified.

**MAXIMUM CAPACITY** means, based on your restrictions and limitations:

- during the first 24 months of disability, the greatest extent of work you are able to do in your regular occupation, that is reasonably available.
- beyond 24 months of disability, the greatest extent of work you are able to do in any occupation, that is reasonably available, for which you are reasonably fitted by education, training or experience.

**MAXIMUM PERIOD OF PAYMENT** means the longest period of time Unum will make payments to you for any one period of disability.
MENTAL ILLNESS means a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association, most current as of the start of a disability. Such disorders include, but are not limited to, psychotic, emotional or behavioral disorders, or disorders relatable to stress. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a disability.

MONTHLY BENEFIT means the total benefit amount for which an employee is insured under this plan subject to the maximum benefit.

MONTHLY EARNINGS means your gross monthly income from your Employer as defined in the plan.

MONTHLY PAYMENT means your payment after any deductible sources of income have been subtracted from your gross disability payment.

PART-TIME BASIS means the ability to work and earn between 20% and 80% of your indexed monthly earnings.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the policy.

PHYSICIAN means:
- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize you, or your spouse, children, parents or siblings as a physician for a claim that you send to us.

PLAN means a line of coverage under the policy.

PRE-EXISTING CONDITION means a condition for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines for your condition during the given period of time as stated in the plan.

RECURRENT DISABILITY means a disability which is:
- caused by a worsening in your condition; and
- due to the same cause(s) as your prior disability for which Unum made a disability payment.
REGULAR CARE means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

REGULAR OCCUPATION means the occupation you are routinely performing when your disability begins. Unum will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.

RETIREMENT PLAN means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to employees and are not funded entirely by employee contributions. Retirement Plan does not include any plan which is part of any governmental retirement system.

SALARY CONTINUATION OR ACCUMULATED SICK LEAVE means continued payments to you by your Employer of all or part of your monthly earnings, after you become disabled as defined by the Policy. This continued payment must be part of an established plan maintained by your Employer for the benefit of all employees covered under the Policy. Salary continuation or accumulated sick leave does not include compensation paid to you by your Employer for work you actually perform after your disability begins. Such compensation is considered disability earnings, and would be taken into account in calculating your monthly payment.

SELF-REPORTED SYMPTOMS means the manifestations of your condition which you tell your physician, that are not verifiable using tests, procedures or clinical examinations standardly accepted in the practice of medicine. Examples of self-reported symptoms include, but are not limited to headaches, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness and loss of energy.

SICKNESS means an illness or disease. Disability must begin while you are covered under the plan.

SURVIVOR, ELIGIBLE means your spouse, if living; otherwise your children under age 25 equally.

WAITING PERIOD means the continuous period of time (shown in each plan) that you must be in active employment in an eligible group before you are eligible for coverage under a plan.


YOU means an employee who is eligible for Unum coverage.
ERISA

Additional Summary Plan Description Information

If this policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your certificate of coverage, constitute the summary plan description. The summary plan description and the policy constitute the Plan. Benefit determinations are controlled exclusively by the policy, your certificate of coverage and the information contained in this document.

Name of Plan:
Children’s Friend and Service Plan

Name and Address of Employer:
Children’s Friend and Service
153 Summer Street
Providence, Rhode Island
02903

Plan Identification Number:
a. Employer IRS Identification #: 05-0258819
b. Plan #: 501

Type of Welfare Plan:
Disability

Type of Administration:
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance policy issued to the Plan.

ERISA Plan Year Ends:
December 31

Plan Administrator, Name, Address, and Telephone Number:
Children’s Friend and Service
153 Summer Street
Providence, Rhode Island
02903
(401) 276-4300

Children’s Friend and Service is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

Agent for Service of
Legal Process on the Plan:
Children’s Friend and Service
153 Summer Street
Providence, Rhode Island
02903
Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

**Funding and Contributions:**
The Plan is funded by insurance issued by Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122 (hereinafter referred to as "Unum") under policy number 395970 011. Contributions to the Plan are made as stated under "WHO PAYS FOR THE COVERAGE" in the Certificate of Coverage.

**EMPLOYER’S RIGHT TO AMEND THE PLAN**

The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of this Plan (including any related documents and underlying policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in writing and endorsed on or attached to the Plan.

**EMPLOYER’S RIGHT TO REQUEST POLICY CHANGE**

The Employer can request a policy change. Only an officer or registrar of Unum can approve a change. The change must be in writing and endorsed on or attached to the policy.

**MODIFYING OR CANCELLING THE POLICY OR A PLAN UNDER THE POLICY**

The policy or a plan under the policy can be cancelled:
- by Unum; or
- by the Policyholder.

Unum may cancel or modify the policy or a plan if:
- there is less than 75% participation of those eligible employees who pay all or part of their premium for a plan; or
- there is less than 100% participation of those eligible employees for a Policyholder paid plan;
- the Policyholder does not promptly provide Unum with information that is reasonably required;
- the Policyholder fails to perform any of its obligations that relate to the policy;
- fewer than 10 employees are insured under a plan;
- the premium is not paid in accordance with the provisions of this policy that specify whether the Policyholder, the employee, or both, pay(s) the premiums;
- the Policyholder does not promptly report to Unum the names of any employees who are added or deleted from the eligible group;
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Policyholder and/or its employees; or
- the Policyholder fails to pay any portion of the premium within the 31 day grace period.
If Unum cancels or modifies the policy or a plan for reasons other than the Policyholder's failure to pay premium, a written notice will be delivered to the Policyholder at least 31 days prior to the cancellation date or modification date. The Policyholder may cancel this policy or a plan if the modifications are unacceptable.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify the policy or plan automatically at the end of the grace period. The Policyholder is liable for premium for coverage during the grace period. The Policyholder must pay Unum all premium due for the full period each plan is in force.

The Policyholder may cancel the policy or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Policyholder and Unum agree, the policy or a plan can be cancelled on an earlier date. If Unum or the Policyholder cancels the policy or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If the policy or a plan is cancelled, the cancellation will not affect a payable claim.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which Unum expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;
- reference specific Plan provision(s) on which the determination is based;
- describe additional material or information necessary to complete the claim and why such information is necessary;
- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit
under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and
- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

**APPEAL PROCEDURES**

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:
- the specific reason(s) for the determination;
- a reference to the specific Plan provision(s) on which the determination is based;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;

- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and

- the statement that "You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

YOUR RIGHTS UNDER ERISA

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
OTHER RIGHTS

Unum, for itself and as claims fiduciary for the Plan, is entitled to legal and equitable relief to enforce its right to recover any benefit overpayments caused by your receipt of deductible sources of income from a third party. This right of recovery is enforceable even if the amount you receive from the third party is less than the actual loss suffered by you but will not exceed the benefits paid you under the policy. Unum and the Plan have an equitable lien over such sources of income until any benefit overpayments have been recovered in full.

DISCRETIONARY ACTS

The Plan, acting through the Plan Administrator, delegates to Unum and its affiliate Unum Group discretionary authority to make benefit determinations under the Plan. Unum and Unum Group may act directly or through their employees and agents or further delegate their authority through contracts, letters or other documentation or procedures to other affiliates, persons or entities. Benefit determinations include determining eligibility for benefits and the amount of any benefits, resolving factual disputes, and interpreting and enforcing the provisions of the Plan. All benefit determinations must be reasonable and based on the terms of the Plan and the facts and circumstances of each claim.

Once you are deemed to have exhausted your appeal rights under the Plan, you have the right to seek court review under Section 502(a) of ERISA of any benefit determinations with which you disagree. The court will determine the standard of review it will apply in evaluating those decisions.
A resident of Rhode Island who purchases life insurance, annuities, long term care or accident and health insurance should know that an insurance company licensed in Rhode Island to write these types of insurance is a member of the Rhode Island Life and Health Insurance Guaranty Association ("Association"). The purpose of the Association is to assure that a policyholder will be protected within the statutory limits, if a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will, within the statutory limits, pay the claims of insured persons who live in this state, and, in some cases, keep coverage in force. However, the protection provided through the Association is not unlimited. This protection is not a substitute for your care in selecting a company that is well managed and financially stable.

LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION DISCLAIMER

The Rhode Island Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned on residence of in this state. Other conditions may also preclude coverage.

The Life and Health Insurance Guaranty Association will respond to any questions you may have which are not answered by this document. Your insurer and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy. You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association when selecting an insurer.

Rhode Island Life and Health Insurance Guaranty Association
235 Promenade Street, #426, Providence, RI 02908
Tel. (401) 273-2921

Rhode Island Division of Insurance
1511 Pontiac Avenue, Cranston, RI 02920
Tel. (401) 462-9520

The full text of the state law that provides for this safety-net coverage, Rhode Island Life and Health Insurance Guaranty Association Act, ("the Act"), can be found beginning at R.I. Gen. Laws §27-34.3-3. A brief summary of the Act is provided below. This summary does not cover all provisions of the law, nor does it in any way change your rights or obligations or those of the Association under the Act.

COVERAGE: Generally, individuals will be protected by the Association if the individual lives in Rhode Island and: Holds a life or health insurance contract, long term care
contract or annuity contract; or is insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live elsewhere.

EXCLUSIONS FROM COVERAGE: The Association does NOT protect a person holding a policy if:

- the individual is eligible for protection under a similar law of another state;
- the insurer was not authorized to do business in this state;
- the policy is issued by an organization that is not a member of the Association;
- the policy was issued by a nonprofit hospital or medical service organization (such as, the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments or by an insurance exchange.

The Association does NOT provide coverage for:

- a policy or portion of a policy not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- a policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed a rate specified by statute;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- an employer's plan to the extent that it is self-funded (that is, not insured by an insurance company, even if an insurance company administers the plan);
- an unallocated annuity contract issued to an employee benefit plan protected under the United States Pension Benefit Guaranty Corporation;
- that part of an unallocated annuity contract not issued to a specific employee, union, association of natural persons benefit plan, or a government lottery;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the insurer;
- any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law;
- an obligation that does not arise under the express written terms of the policy or contract issued by the insurer.
- a policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code (commonly known as Medicare Part C & D) or any regulations issued pursuant thereto.
LIMITATIONS ON COVERAGE: The Act limits the amount the Association is obligated to pay. The Association cannot pay more than what the insurer would have owed under a policy or contract. Also, for any one insured life, no matter how many policies or contracts were in force with the same insurer, the Association will pay no more than:

- $300,000 in net life insurance death benefits and no more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

- $100,000 for health insurance benefits, coverages not defined as disability, basic hospital, medical, and surgical, major medical insurance, or long term care insurance including any net cash surrender and net cash withdrawal values;

- $300,000 for disability insurance;

- $300,000 for long term care insurance;

- $500,000 for basic hospital, medical, and surgical or major medical insurance;

- $250,000 in present value of annuity benefits, including net cash surrender and net cash withdrawal value;

- $250,000 in present value per payee with respect to a structured settlement annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;

- $250,000, in the aggregate, in present value of annuity benefits, including net cash surrender and net cash withdrawal values, with respect to an individual participating in a governmental retirement plan established under 26 U.S.C. §§401, 403(b), or 457 and covered by an unallocated annuity contract, or the beneficiaries of the each such individual if the individual is deceased;

- $5,000,000 in unallocated annuity contract benefits, irrespective of the number of contracts, with respect to the contract owner or plan sponsor whose plan owns, directly or in trust, one or more unallocated annuity contracts.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the Act: for unallocated annuities that fund government retirement plans under sections 401(k), 403(b), or 457 of the Internal Revenue Code, the limit is $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the Association be liable to spend more than $300,000 in the aggregate per individual except hospital insurance up to $500,000 per individual. For covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases the contract limits also apply.

These general statements as to Limitations on Coverage are only summaries of the law. The actual limitations are set forth in R.I. Gen. Laws §27-34.3-3.

All alleged violations of the provisions of the Rhode Island Life and Health Insurance Guaranty Association Act may be reported to the Rhode Island Division of Insurance at the address and telephone number above.
This information is provided by: The Association and by the Division of Insurance, whose respective addresses are provided in the Disclaimer, above.
Children's Friend and Service

Your Group Life Insurance Plan

Identification No.  395971  011

Underwritten by Unum Life Insurance Company of America

2/4/2013
CERTIFICATE OF COVERAGE

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the Summary of Benefits (issued to the Employer), the Summary of Benefits will govern. The Summary of Benefits may be changed in whole or in part. Only an officer or registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to the Summary of Benefits. Any other person, including an agent, may not change the Summary of Benefits or waive any part of it.

The Summary of Benefits is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. When making a benefit determination under the Summary of Benefits, Unum has discretionary authority to determine your eligibility for benefits and to interpret the terms and provisions of the Summary of Benefits.

For purposes of effective dates and ending dates under the group Summary of Benefits, all days begin at 12:01 a.m. and end at 12:00 midnight at the Employer's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122
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BENEFITS AT A GLANCE

LIFE INSURANCE PLAN

This life insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death. The amount your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death according to the terms and provisions of the plan. You also have the opportunity to have coverage for your dependents.

EMPLOYER'S ORIGINAL PLAN

EFFECTIVE DATE: January 1, 2013

PLAN YEAR:

January 1, 2013 to January 1, 2014 and each following January 1 to January 1

IDENTIFICATION NUMBER: 395971 011

ELIGIBLE GROUP(S):

All Full-Time Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 20 hours per week.

WAITING PERIOD:

For employees in an eligible group on or before January 1, 2013: None

For employees entering an eligible group after January 1, 2013: First of the month coincident with or next following the date you enter an eligible group

REHIRE:

If your employment ends and you are rehired within 1 year, your previous work while in an eligible group will apply toward the waiting period. All other Summary of Benefits' provisions apply.

WHO PAYS FOR THE COVERAGE:

For You:

You pay the cost of your coverage.

For Your Dependents:

You pay the cost of your dependent coverage.

ELIMINATION PERIOD:

Premium Waiver: 9 months

Disability-based benefits begin the day after Unum approves your claim and the elimination period is completed.
LIFE INSURANCE BENEFIT:

AMOUNT OF LIFE INSURANCE FOR YOU

Amounts in $10,000 benefit units as applied for by you and approved by Unum.

All amounts are rounded to the next higher multiple of $10,000, if not already an exact multiple thereof.

AMOUNT OF LIFE INSURANCE AVAILABLE IF YOU BECOME INSURED AT CERTAIN AGES OR HAVE REACHED CERTAIN AGES WHILE INSURED

If you have reached age 70, but not age 75, your amount of life insurance will be:
- 65% of the amount of life insurance you had prior to age 70; or
- 65% of the amount of life insurance shown above if you become insured on or after age 70 but before age 75.

There will be no further increases in your amount of life insurance.

If you have reached age 75 or more, your amount of life insurance will be:
- 50% of the amount of life insurance you had prior to your first reduction; or
- 50% of the amount of life insurance shown above if you become insured on or after age 75.

There will be no further increases in your amount of life insurance.

EVIDENCE OF INSURABILITY IS REQUIRED FOR THE AMOUNT OF YOUR INSURANCE OVER:

$110,000

Evidence of Insurability is not required for amounts of life insurance you had in force with your Employer's prior carrier on the termination date of the prior carrier's plan.

Evidence of Insurability is required for amounts of life insurance in excess of the greater of:
- The amount(s) of life insurance you had in force with your Employer's prior carrier on the termination date of the prior carrier's plan; or
- The amount(s) of life insurance over the amount shown above.

OVERALL MAXIMUM BENEFIT OF LIFE INSURANCE FOR YOU:

The lesser of:
- 5 x annual earnings; or
- $500,000.

AMOUNT OF LIFE INSURANCE FOR YOUR DEPENDENTS

Spouse:

Amounts in $5,000 benefit units as applied for by you and approved by Unum.

All amounts are rounded to the next higher multiple of $5,000, if not already an exact multiple thereof.

THE AMOUNT OF YOUR SPOUSE’S LIFE INSURANCE WILL REDUCE BY THE SAME PERCENTAGE AND AT THE SAME TIME YOUR LIFE INSURANCE REDUCES.

EVIDENCE OF INSURABILITY IS REQUIRED FOR THE AMOUNT OF YOUR SPOUSE’S INSURANCE OVER:

$25,000

Evidence of Insurability is not required for amounts of life insurance your spouse had in force with your Employer's prior carrier on the termination date of the prior carrier's plan.

Evidence of Insurability is required for amounts of life insurance in excess of the greater of:
- The amount(s) of life insurance your spouse had in force with your Employer's prior carrier on the termination date of the prior carrier's plan; or
- The amount(s) of life insurance over the amount shown above.

MAXIMUM BENEFIT OF LIFE INSURANCE FOR YOUR SPOUSE:

The lesser of:
- 100% of your amount of insurance; or
- $500,000.

Children:

Amounts in $2,000 benefit units as applied for by you and approved by Unum.

All amounts are rounded to the next higher multiple of $2,000, if not already a multiple thereof.

MAXIMUM BENEFIT OF LIFE INSURANCE FOR YOUR CHILDREN:

Attained age at death:

Live birth to 14 days: $1,000
14 days to 6 months: $1,000
6 months to age 19 or to age 26 if a full-time student:

The lesser of:
- 100% of your amount of insurance; or
- $10,000.

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Accelerated Benefit
Conversion
Portability

NOTE: Portability under this plan is available to an insured spouse in the event of divorce from an insured employee, subject to all terms and conditions otherwise applicable to ported spouse coverage.

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section. The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.
CLAIM INFORMATION

LIFE INSURANCE

WHEN DO YOU OR YOUR AUTHORIZED REPRESENTATIVE NOTIFY UNUM OF A CLAIM?

We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on your disability, written notice and proof of claim must be sent no later than 90 days after the end of the elimination period.

If a claim is based on death, written notice and proof of claim must be sent no later than 90 days after the date of death.

If it is not possible to give proof within these time limits, it must be given no later than 1 year after the proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

The claim form is available from your Employer, or you or your authorized representative can request a claim form from us. If you or your authorized representative does not receive the form from Unum within 15 days of the request, send Unum written proof of claim without waiting for the form.

If you have a disability, you must notify us immediately when you return to work in any capacity, regardless of whether you are working for your Employer.

HOW DO YOU FILE A CLAIM FOR A DISABILITY?

You or your authorized representative, and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

If your claim is based on your disability, your proof of claim, provided at your expense, must show:

- that you are under the regular care of a physician;
- the date your disability began;
- the cause of your disability;
- the extent of your disability, including restrictions and limitations preventing you from performing your regular occupation or any gainful occupation; and
- the name and address of any hospital or institution where you received treatment, including all attending physicians.

We may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 45 days of a request by us.
If claim is based on death, proof of claim, provided at your or your authorized representative’s expense, must show the cause of death. Also a certified copy of the death certificate must be given to us.

In some cases, you will be required to give Unum authorization to obtain additional medical and non-medical information as part of your proof of claim or proof of continuing disability. Unum will deny your claim if the appropriate information is not submitted.

WHEN CAN UNUM REQUEST AN AUTOPSY?

In the case of death, Unum will have the right and opportunity to request an autopsy where not forbidden by law.

HOW DO YOU DESIGNATE OR CHANGE A BENEFICIARY? (Beneficiary Designation)

At the time you become insured, you should name a beneficiary on your enrollment form for your death benefits under your life insurance. You may change your beneficiary at any time by filing a form approved by Unum with your Employer. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before your Employer receives that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, Unum has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If we are to make payments to a beneficiary who lacks the legal capacity to give us a release, Unum may pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This payment made in good faith satisfies Unum’s legal duty to the extent of that payment and Unum will not have to make payment again.

Also, at Unum’s option, we may pay up to $1,000 to the person or persons who, in our opinion, have incurred expenses for your last sickness and death.
In addition, if you do not survive your spouse, and dependent life coverage is continued, then your surviving spouse should name a beneficiary according to the requirements specified above for you.

**HOW WILL UNUM MAKE PAYMENTS?**

If your or your dependent's life claim is at least $10,000, Unum will make available to the beneficiary a **retained asset account** (the Unum Security Account).

Payment for the life claim may be accessed by writing a draft in a single sum or drafts in smaller sums. The funds for the draft or drafts are fully guaranteed by Unum.

If the life claim is less than $10,000, Unum will pay it in one lump sum to you or your beneficiary.

Also, you or your beneficiary may request the life claim to be paid according to one of Unum's other settlement options. This request must be in writing in order to be paid under Unum's other settlement options.

If you do not survive your spouse, and dependent life coverage is continued, then your surviving spouse's death claim will be paid to your surviving spouse's beneficiary.

All other benefits will be paid to you.

**WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?**

Unum has the right to recover any overpayments due to:

- fraud; and
- any error Unum makes in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

**WHAT ARE YOUR ASSIGNABILITY RIGHTS FOR THE DEATH BENEFITS UNDER YOUR LIFE INSURANCE? (Assignability Rights)**

The rights provided to you by the plan for life insurance are owned by you, unless:

- you have previously assigned these rights to someone else (known as an "assignee"); or
- you assign your rights under the plan(s) to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by you, and acceptable to us in form; and
- a signed or certified copy of the written assignment has been received and registered by us at our home office.
We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan(s') provisions before receiving and registering an assignment.
GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are working for your Employer in an eligible group, the date you are eligible for coverage is the later of:

- the plan effective date; or
- the day after you complete your waiting period.

WHEN DOES YOUR LIFE INSURANCE COVERAGE BEGIN?

This plan provides benefit units that you can choose. When you first become eligible for coverage, you may apply for any number of benefit units, however, you cannot be covered for more than the maximum benefit available under the plan.

Evidence of insurability is required for any amount of life insurance over the amount shown in the LIFE INSURANCE "BENEFITS AT A GLANCE" page.

You pay 100% of the cost yourself for any benefit unit. You will be covered at 12:01 a.m. on the later of:

- the first of the month coincident with or next following the date you are eligible for coverage, if you apply for insurance on or before that date, for any amount of insurance that is not subject to evidence of insurability requirements; or
- the first of the month coincident with or next following the date you apply for insurance, if you apply within 31 days after your eligibility date, for any amount of insurance that is not subject to evidence of insurability requirements; and
- the first of the month coincident with or next following the date Unum approves your evidence of insurability form, if you apply for insurance on or before your eligibility date or within 31 days after your eligibility date, for any amount of insurance that is subject to evidence of insurability requirements.

WHEN CAN YOU APPLY FOR LIFE INSURANCE COVERAGE IF YOU APPLY MORE THAN 31 DAYS AFTER YOUR ELIGIBILITY DATE?

You can apply for coverage only during an annual enrollment period. Evidence of insurability is required for any amount of insurance.

Unum and your Employer determine when the annual enrollment period begins and ends. Coverage will begin at 12:01 a.m. on the first of the month coincident with or next following the date Unum approves your evidence of insurability form.
WHEN CAN YOU CHANGE YOUR LIFE INSURANCE COVERAGE?

You can change your coverage by applying for additional benefit units at anytime during the plan year. You can increase your coverage any number of benefit units up to the maximum benefit available under the plan. Evidence of insurability is required for any amount of life insurance applied for during the plan year. A change in coverage that is made during a plan year will begin at 12:01 a.m. on the first of the month coincident with or next following the date Unum approves your evidence of insurability form.

You also can change your coverage by applying for additional benefit units during an annual enrollment period. You can increase your coverage any number of benefit units up to the maximum benefit available under the plan.

Evidence of insurability is required for any amount of life insurance over the amount shown in the LIFE INSURANCE "BENEFITS AT A GLANCE" page.

Unum and your Employer determine when the annual enrollment period begins and ends. A change in coverage that is made during an annual enrollment period will begin at 12:01 a.m. on:

- the first day of the next plan year for any amount of insurance that is not subject to evidence of insurability requirements; and
- the first of the month coincident with or next following the date Unum approves your evidence of insurability form for any amount of insurance that is subject to evidence of insurability requirements.

In addition, you can decrease your coverage any number of benefit units during the plan year or annual enrollment period. Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?

If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the first of the month coincident with or next following the date you return to active employment.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE NOT WORKING DUE TO INJURY OR SICKNESS?

If you are not working due to injury or sickness, and if premium is paid, you may continue to be covered up to your retirement date.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?

If you are on a temporary layoff, and if premium is paid, you will be covered through the end of the month that immediately follows the month in which your temporary layoff begins.

If you are on a leave of absence, and if premium is paid, you will be covered through the end of the month that immediately follows the month in which your leave of absence begins.
WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?

Once your coverage begins, any increased or additional coverage due to a change in your annual earnings or due to a plan change requested by your Employer will take effect on the first of the month coincident with or next following the date the change occurs or on the first of the month coincident with or next following the date Unum approves your evidence of insurability form, if evidence of insurability is required. You must be in active employment or on a covered layoff or leave of absence.

If you are not in active employment due to injury or sickness, any increased or additional coverage due to a change in your annual earnings or due to a plan change will begin on the first of the month coincident with or next following the date you return to active employment.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

WHEN DOES YOUR COVERAGE END?

Your coverage under the Summary of Benefits or a plan ends on the earliest of:

- the date the Summary of Benefits or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in this certificate of coverage.

Unum will provide coverage for a payable claim which occurs while you are covered under the Summary of Benefits or plan.

WHEN ARE YOU ELIGIBLE TO ELECT DEPENDENT COVERAGE?

If you elect coverage for yourself or are insured under the plan, you are eligible to elect dependent coverage for your spouse only, your dependent children only or both.

WHEN ARE YOUR DEPENDENTS ELIGIBLE FOR COVERAGE?

The date your dependents are eligible for coverage is the later of:

- the date your insurance begins; or
- the date you first acquire a dependent.

WHAT DEPENDENTS ARE ELIGIBLE FOR COVERAGE?

The following dependents are eligible for coverage under the plan:

- Your lawful spouse, including a legally separated spouse. You may not cover your spouse as a dependent if your spouse is enrolled for coverage as an employee.
- Your unmarried children from live birth but less than age 19. Stillborn children are not eligible for coverage.

- Your unmarried dependent children age 19 or over but under age 26 also are eligible if they are full-time students at an accredited school.

Children include your own natural offspring, lawfully adopted children and stepchildren. They also include foster children and other children who are dependent on you for main support and living with you in a regular parent-child relationship. A child will be considered adopted on the date of placement in your home.

No dependent child may be covered by more than one employee in the plan.

No dependent child can be covered as both an employee and a dependent.

**WHEN DOES YOUR DEPENDENT LIFE INSURANCE COVERAGE BEGIN?**

This plan provides benefit units that you can choose for your dependents. When your dependents first become eligible for coverage, you may apply for any number of benefit units, however, your dependents cannot be covered for more than the maximum benefits available under the plan.

Evidence of insurability is required for any amount of dependent life insurance over the amount shown in the LIFE INSURANCE "BENEFITS AT A GLANCE" page.

You pay 100% of the cost yourself for dependent coverage. Your dependents will be covered at 12:01 a.m. on the later of:

- the first of the month coincident with or next following the date your dependents are eligible for coverage, if you apply for dependent insurance on or before that date, for any amount of insurance that is not subject to evidence of insurability requirements; or
- the first of the month coincident with or next following the date you apply for dependent insurance, if you apply for dependent insurance within 31 days after your dependent's eligibility date, for any amount of insurance that is not subject to evidence of insurability requirements; and
- the first of the month coincident with or next following the date Unum approves your dependent's evidence of insurability form, if you apply for dependent insurance on or before your dependent's eligibility date or within 31 days after your dependent's eligibility date for any amount of insurance that is subject to evidence of insurability requirements.

**WHEN CAN YOU APPLY FOR DEPENDENT LIFE INSURANCE COVERAGE IF YOU APPLY MORE THAN 31 DAYS AFTER YOUR DEPENDENT'S ELIGIBILITY DATE?**

You can apply for dependent coverage only during an annual enrollment period. Evidence of insurability is required for any amount of dependent life insurance.

Unum and your Employer determine when the annual enrollment period begins and ends. Dependent coverage will begin at 12:01 a.m. on the first of the month coincident with or next following the date Unum approves your dependent's evidence of insurability form.
WHEN CAN YOU CHANGE YOUR DEPENDENT LIFE INSURANCE COVERAGE?

You can change your dependent coverage by applying for additional benefit units at anytime during the plan year. You can increase your dependent coverage any number of benefit units up to the maximum benefits available under the plan. Evidence of insurability is required for any amount of dependent life insurance applied for during the plan year. A change in coverage that is made during a plan year will begin at 12:01 a.m. on the first of the month coincident with or next following the date Unum approves your dependent's evidence of insurability form.

You also can change your dependent coverage by applying for additional benefit units during an annual enrollment period. You can increase your dependent coverage any number of benefit units up to the maximum benefits available under the plan.

Evidence of insurability is required for any amount of dependent life insurance over the amount shown in the LIFE INSURANCE "BENEFITS AT A GLANCE" page.

Unum and your Employer determine when the annual enrollment period begins and ends. A change in coverage that is made during an annual enrollment period will begin at 12:01 a.m. on:

- the first day of the next plan year for any amount of insurance that is not subject to evidence of insurability requirements; and
- the first of the month coincident with or next following the date Unum approves your dependent's evidence of insurability form for any amount of insurance that is subject to evidence of insurability requirements.

In addition, you can decrease your dependent coverage any number of benefit units during the plan year or annual enrollment period. Any decrease in dependent coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

WHAT IF YOUR DEPENDENT IS TOTALLY DISABLED ON THE DATE YOUR DEPENDENT'S COVERAGE WOULD NORMALLY BEGIN?

If your eligible dependent is totally disabled, your dependent’s coverage will begin on the first of the month coincident with or next following the date your eligible dependent no longer is totally disabled. This provision does not apply to a newborn child while dependent insurance is in effect.

WHEN WILL CHANGES TO YOUR DEPENDENT'S COVERAGE TAKE EFFECT?

Once your dependent's coverage begins, any increased or additional dependent coverage due to a plan change requested by your Employer will take effect on the first of the month coincident with or next following the date the change occurs or on the first of the month coincident with or next following the date Unum approves your dependent's evidence of insurability form, if evidence of insurability is required, provided your dependent is not totally disabled. You must be in active employment or on a covered layoff or leave of absence.
If you are not in active employment due to injury or sickness, any increased or additional dependent coverage due to a plan change will begin on the first of the month coincident with or next following the date you return to active employment.

If your dependent is totally disabled, any increased or additional dependent coverage will begin on the first of the month coincident with or next following the date your dependent is no longer totally disabled.

Any decreased coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

**WHEN DOES YOUR DEPENDENT'S COVERAGE END?**

Your dependent's coverage under the Summary of Benefits or a plan ends on the earliest of:

- the date the Summary of Benefits or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the date of your death;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in this certificate of coverage.

Coverage for any one dependent will end on the earliest of:

- the date your coverage under a plan ends;
- the date your dependent ceases to be an eligible dependent;
- for a spouse, the date of divorce or annulment.

Unum will provide coverage for a payable claim which occurs while your dependents are covered under the Summary of Benefits or plan.

**WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?**

You or your authorized representative can start legal action regarding a claim 60 days after proof of claim has been given and up to 3 years from the time proof of claim is required, unless otherwise provided under federal law.

**HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?**

Unum considers any statements you or your Employer make in a signed application for coverage or an evidence of insurability form a representation and not a warranty. If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

We will use only statements made in a signed application or an evidence of insurability form as a basis for doing this.
Except in the case of fraud, Unum can take action only in the first 2 years coverage is in force.

If the Employer gives us information about you that is incorrect, we will:

- use the facts to decide whether you have coverage under the plan and in what amounts; and
- make a fair adjustment of the premium.

**HOW WILL UNUM HANDLE INSURANCE FRAUD?**

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

**DOES THE SUMMARY OF BENEFITS REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?**

The Summary of Benefits does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

**DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?**

For the purposes of the Summary of Benefits, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.
WHEN WILL YOUR BENEFICIARY RECEIVE PAYMENT?

Your beneficiary(ies) will receive payment when Unum approves your death claim.

WHAT DOCUMENTS ARE REQUIRED FOR PROOF OF DEATH?

Unum will require a certified copy of the death certificate, enrollment documents and a Notice and Proof of Claim form.

HOW MUCH WILL UNUM PAY YOU IF UNUM APPROVES YOUR DEPENDENT’S DEATH CLAIM?

Unum will determine the payment according to the amount of insurance shown in the LIFE INSURANCE "BENEFITS AT A GLANCE" page.

HOW MUCH WILL UNUM PAY YOUR BENEFICIARY IF UNUM APPROVES YOUR DEATH CLAIM?

Unum will determine the payment according to the amount of insurance shown in the LIFE INSURANCE "BENEFITS AT A GLANCE" page.

WHAT ARE YOUR ANNUAL EARNINGS?

"Annual Earnings" means your gross annual income from your Employer in effect just prior to the date of loss. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation or income received from sources other than your Employer.

WHAT WILL WE USE FOR ANNUAL EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?

If you become disabled while you are on a covered layoff or leave of absence, we will use your annual earnings from your Employer in effect just prior to the date your absence began.

WHAT HAPPENS TO YOUR LIFE INSURANCE COVERAGE IF YOU BECOME DISABLED?

Your life insurance coverage may be continued for a specific time and your life insurance premium will be waived if you qualify as described below.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO HAVE LIFE PREMIUMS WAIVED?

You must be disabled through your elimination period.

Your elimination period is 9 months.
WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER BEGIN?

Your life insurance premium waiver will begin when we approve your claim, if the elimination period has ended and you meet the following conditions. Your Employer may continue premium payments until Unum notifies your Employer of the date your life insurance premium waiver begins.

Your life insurance premium will be waived if you meet these conditions:

- you are less than 60 and insured under the plan.
- you become disabled and remain disabled during the elimination period.
- you meet the notice and proof of claim requirements for disability while your life insurance is in effect or within three months after it ends.
- your claim is approved by Unum.

After we approve your claim, Unum does not require further premium payments for you while you remain disabled according to the terms and provisions of the plan.

Your life insurance amount will not increase while your life insurance premiums are being waived. Your life insurance amount will reduce or cease at any time it would reduce or cease if you had not been disabled.

WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER END?

The life insurance premium waiver will automatically end if:

- you recover and you no longer are disabled;
- you fail to give us proper proof that you remain disabled;
- you refuse to have an examination by a physician chosen by Unum;
- you reach age 65; or
- premium has been waived for 12 months and you are considered to reside outside the United States. You will be considered to reside outside the United States when you have been outside the United States for a total period of 6 months or more during any 12 consecutive months for which premium has been waived.

HOW DOES UNUM DEFINE DISABILITY?

You are disabled when Unum determines that:

- during the elimination period, you are not working in any occupation due to your injury or sickness; and
- after the elimination period, due to the same injury or sickness, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by training, education or experience.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

We may require you to be examined by a physician, other medical practitioner or vocational expert of our choice. Unum will pay for this examination. We can require
an examination as often as it is reasonable to do so. We may also require you to be interviewed by an authorized Unum Representative.

**APPLYING FOR LIFE INSURANCE PREMIUM WAIVER**

Ask your Employer for a life insurance premium waiver claim form.

The form has instructions on how to complete and where to send the claim.

**WHAT INSURANCE IS AVAILABLE WHILE YOU ARE SATISFYING THE DISABILITY REQUIREMENTS? (See Conversion Privilege)**

You may use this life conversion privilege when your life insurance terminates while you are satisfying the disability requirements. Please refer to the conversion privilege below. You are not eligible to apply for this life conversion if you return to work and, again, become covered under the plan.

If an individual life insurance policy is issued to you, any benefit for your death under this plan will be paid only if the individual policy is returned for surrender to Unum. Unum will refund all premiums paid for the individual policy.

The amount of your death benefit will be paid to your named beneficiary for the plan. If, however, you named a different beneficiary for the individual policy and the policy is returned to Unum for surrender, that different beneficiary will not be paid.

If you want to name a different beneficiary for this group plan, you must change your beneficiary as described in the Beneficiary Designation page of this group plan.

**WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)**

When coverage ends under the plan, you and your dependents can convert your coverages to individual life policies, without evidence of insurability. The maximum amounts that you can convert are the amounts you and your dependents are insured for under the plan. You may convert a lower amount of life insurance.

You and your dependents must apply for individual life insurance under this life conversion privilege and pay the first premium within 31 days after the date:

- your employment terminates; or
- you or your dependents no longer are eligible to participate in the coverage of the plan.

If you convert to an individual life policy, then return to work, and, again, become insured under the plan, you are not eligible to convert to an individual life policy again. However, you do not need to surrender that individual life policy when you return to work.

Converted insurance may be of any type of the level premium whole life plans then in use by Unum. The person may elect one year of Preliminary Term insurance under the level premium whole life policy. The individual policy will not contain disability or other extra benefits.
WHAT LIMITED CONVERSION IS AVAILABLE IF THE SUMMARY OF BENEFITS OR THE PLAN IS CANCELLED? (Conversion Privilege)

You and your dependents may convert a limited amount of life insurance if you have been insured under your Employer’s group plan with Unum for at least five (5) years and the Summary of Benefits or the plan:

- is cancelled with Unum; or
- changes so that you no longer are eligible.

The individual life policy maximum for each of you will be the lesser of:

- $10,000; or
- your or your dependent’s coverage amounts under the plan less any amounts that become available under any other group life plan offered by your Employer within 31 days after the date the Summary of Benefits or the plan is cancelled.

PREMIUMS

Premiums for the converted insurance will be based on:

- the person’s then attained age on the effective date of the individual life policy;
- the type and amount of insurance to be converted;
- Unum’s customary rates in use at that time; and
- the class of risk to which the person belongs.

If the premium payment has been made, the individual life policy will be effective at the end of the 31 day conversion application period.

DEATH DURING THE THIRTY-ONE DAY CONVERSION APPLICATION PERIOD

If you or your dependents die within the 31 day conversion application period, Unum will pay the beneficiary(ies) the amount of insurance that could have been converted. This coverage is available whether or not you have applied for an individual life policy under the conversion privilege.

APPLYING FOR CONVERSION

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit
2211 Congress Street
Portland, Maine 04122-1350
1-800-343-5406
WILL UNUM ACCELERATE YOUR OR YOUR DEPENDENT'S DEATH BENEFIT FOR THE PLAN IF YOU OR YOUR DEPENDENT BECOMES TERMINALLY ILL?  
(Accelerated Benefit)

If you or your dependent becomes terminally ill while you or your dependent is insured by the plan, Unum will pay you a portion of your or your dependent's life insurance benefit one time. The payment will be based on 50% of your or your dependent's life insurance amount. However, the one-time benefit paid will not be greater than $750,000.

Your or your dependent's right to exercise this option and to receive payment is subject to the following:

- you or your dependent requests this election, in writing, on a form acceptable to Unum;
- you or your dependent must be terminally ill at the time of payment of the Accelerated Benefit;
- your or your dependent's physician must certify, in writing, that you or your dependent is terminally ill and your or your dependent's life expectancy has been reduced to less than 12 months; and
- the physician's certification must be deemed satisfactory to Unum.

The Accelerated Benefit is available on a voluntary basis. Therefore, you or your dependent is not eligible for benefits if:

- you or your dependent is required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or
- you or your dependent is required by a government agency to use this benefit in order to apply for, get, or otherwise keep a government benefit or entitlement.

Premium payments must continue to be paid on the full amount of life insurance unless you qualify to have your life premium waived.

Also, premium payments must continue to be paid on the full amount of your dependent's life insurance.

If you have assigned your rights under the plan to an assignee or made an irrevocable beneficiary designation, Unum must receive consent, in writing, that the assignee or irrevocable beneficiary has agreed to the Accelerated Benefit payment on your behalf in a form acceptable to Unum before benefits are payable.

An election to receive an Accelerated Benefit will have the following effect on other benefits:

- the death benefit payable will be reduced by any amount of Accelerated Benefit that has been paid; and
- any amount of life insurance that would be continued under a disability continuation provision or that may be available under the conversion privilege will be reduced by the amount of the Accelerated Benefit paid. The remaining life insurance amount will be paid according to the terms of the Summary of Benefits subject to any reduction and termination provisions.
Benefits paid may be taxable. Unum is not responsible for any tax or other effects of any benefit paid. As with all tax matters, you or your dependent should consult your personal tax advisor to assess the impact of this benefit.

**WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?**

Your plan does not cover any losses where death is caused by, contributed to by, or results from:

- suicide occurring within 24 months after your or your dependent's initial effective date of insurance; and
- suicide occurring within 24 months after the date any increases or additional insurance become effective for you or your dependent.

The suicide exclusion will apply to any amounts of insurance for which you pay all or part of the premium.

The suicide exclusion also will apply to any amount that is subject to evidence of insurability requirements and Unum approves the evidence of insurability form and the amount you or your dependent applied for at that time.
LIFE INSURANCE

OTHER BENEFIT FEATURES

WHAT COVERAGE IS AVAILABLE IF YOU END EMPLOYMENT OR YOU WORK REDUCED HOURS? (Portability)

If your employment ends with or you retire from your Employer or you are working less than the minimum number of hours as described under Eligible Groups in this plan, you may elect portable coverage for yourself and your dependents.

In case of your death, your insured dependents also may elect portable coverage for themselves. However, children cannot become insured for portable coverage unless the spouse also becomes insured for portable coverage.

PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE

The portable insurance coverage will be the current coverage and amounts that you and your dependents are insured for under your Employer’s group plan.

However, the amount of portable coverage for you will not be more than:

- the highest amount of life insurance available for employees under the plan; or
- 5x your annual earnings; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The amount of portable coverage for your spouse will not be more than:

- the highest amount of life insurance available for spouses under the plan; or
- 100% of your amount of portable coverage; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The amount of portable coverage for a child will not be more than:

- the highest amount of life insurance available for children under the plan; or
- 100% of your amount of portable coverage; or
- $20,000,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.
The minimum amount of coverage that can be ported is $5,000 for you and $1,000 for your dependents. If the current amounts under the plan are less than $5,000 for you and $1,000 for your dependents you and your dependents may port the lesser amounts.

Your or your dependent’s amount of life insurance will reduce or cease at any time it would reduce or cease for your eligible group if you had continued in active employment with your Employer.

**APPLYING FOR PORTABLE COVERAGE**

You must apply for portable coverage for yourself and your dependents and pay the first premium within 31 days after the date:

- your coverage ends or you retire from your Employer; or
- you begin working less than the minimum number of hours as described under Eligible Groups in this plan.

Your dependents must apply for portable coverage and pay the first premium within 31 days after the date you die.

You are not eligible to apply for portable coverage for yourself if:

- you have an **injury** or **sickness**, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan.

You are not eligible to apply for portable coverage for a dependent if:

- you do not elect portable coverage for yourself;
- you have an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- your dependent has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan.

In case of your death, your spouse is not eligible to apply for portable coverage if:

- your surviving spouse is not insured under this plan;
- your surviving spouse has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan for your spouse.

In case of your death, your child is not eligible for portable coverage if:

- your surviving spouse is not insured under this plan;
- your surviving spouse is insured under this plan and chooses not to elect portable coverage;
- your surviving spouse has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- your child has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates); or
- you failed to pay the required premium under the terms of this plan for your child.

If we determine that because of an injury or sickness, which has a material effect on life expectancy, you or your dependents were not eligible for portability at the time you or your dependents elected portable coverage, the benefit will be adjusted to the amount of whole life coverage the premium would have purchased under the Conversion Privilege.

**APPLYING FOR INCREASES OR DECREASES IN PORTABLE COVERAGE**

You or your dependents may increase or decrease the amount of life insurance coverage. The minimum and maximum benefit amounts are shown above. However, the amount of life insurance coverage cannot be decreased below $5,000 for you and $1,000 for your dependents. All increases are subject to evidence of insurability. Portable coverage will reduce at the ages and amounts shown in the LIFE INSURANCE "BENEFITS AT A GLANCE" page.

**ADDING PORTABLE COVERAGE FOR DEPENDENTS**

If you choose not to enroll your dependents when your dependents were first eligible for portable coverage, you may enroll your dependents at any time for the amounts allowed under the group plan. Evidence of insurability is required.

You may enroll newly acquired dependents at any time for the amounts allowed under the group plan. Evidence of insurability is required.

**WHEN PORTABLE COVERAGE ENDS**

Portable coverage for you will end for the following reasons:

- the date you fail to pay any required premium; or
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates).

Portable coverage for a spouse will end for the following reasons:

- the date you fail to pay any required premium;
- the date your surviving spouse fails to pay any required premium; or
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates).

Portable coverage for a child will end for the following reasons:

- the date you fail to pay any required premium;
- the date your surviving spouse fails to pay any required premium;
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Employer participates);
- the date your child no longer qualifies as a dependent; or
- the date the surviving spouse dies.

If portable coverage ends due to failure to pay required premium, portable coverage cannot be reinstated.

**PREMIUM RATE CHANGES FOR PORTABLE COVERAGE**

Unum may change premium rates for portable coverage at any time for reasons which affect the risk assumed, including those reasons shown below:

- changes occur in the coverage levels;
- changes occur in the overall use of benefits by all insureds;
- changes occur in other risk factors; or
- a new law or a change in any existing law is enacted which applies to portable coverage.

The change in premium rates will be made on a class basis according to Unum's underwriting risk studies. Unum will notify the insured in writing at least 31 days before a premium rate is changed.

**APPLYING FOR CONVERSION, IF PORTABLE COVERAGE ENDS OR IS NOT AVAILABLE**

If you or your dependent is not eligible to apply for portable coverage or portable coverage ends, then you or your dependent may qualify for conversion coverage. Refer to Conversion Privilege under this plan.

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit
2211 Congress Street
Portland, Maine  04122-1350
1-800-343-5406
GLOSSARY

ACCREDITED SCHOOL means an accredited post-secondary institution of higher learning for full-time students beyond the 12th grade level.

ACTIVE EMPLOYMENT means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under Eligible Group(s) in each plan.

Your work site must be:

- your Employer's usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment. Temporary and seasonal workers are excluded from coverage.

ACTIVITIES OF DAILY LIVING means:

- Bathing - the ability to wash oneself either in the tub or shower or by sponge bath with or without equipment or adaptive devices.
- Dressing - the ability to put on and take off all garments and medically necessary braces or artificial limbs usually worn.
- Toileting - the ability to get to and from and on and off the toilet; to maintain a reasonable level of personal hygiene, and to care for clothing.
- Transferring - the ability to move in and out of a chair or bed with or without equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices including mechanical or motorized devices.
- Continence - the ability to either:
  - voluntarily control bowel and bladder function; or
  - if incontinent, be able to maintain a reasonable level of personal hygiene.
- Eating - the ability to get nourishment into the body.

A person is considered unable to perform an activity of daily living if the task cannot be performed safely without another person's stand-by assistance or verbal cueing.

ANNUAL EARNINGS means your annual income received from your Employer as defined in the plan.

ANNUAL ENROLLMENT PERIOD means a period of time before the beginning of each plan year and ending on the plan anniversary date.

COGNITIVELY IMPAIRED means a person has a deterioration or loss in intellectual capacity resulting from injury, sickness, advanced age, Alzheimer's disease or similar forms of irreversible dementia and needs another person's assistance or verbal cueing for his or her own protection or for the protection of others.

ELIMINATION PERIOD means a period of continuous disability which must be satisfied before you are eligible to have your life premium waived by Unum.

EMPLOYEE means a person who is in active employment in the United States with the Employer.
EMPLOYER means the Employer/Applicant named in the Application For Participation in the Select Group Insurance Trust, on the first page of the Summary of Benefits and in all amendments. It includes any division, subsidiary or affiliated company named in the Summary of Benefits.

EVIDENCE OF INSURABILITY means a statement of your or your dependent’s medical history which Unum will use to determine if you or your dependent is approved for coverage. Evidence of insurability will be at Unum’s expense.

GAINFUL OCCUPATION means an occupation that within 12 months of your return to work is or can be expected to provide you with an income that is at least equal to 60% of your annual earnings in effect just prior to the date your disability began.

GRACE PERIOD means the period of time following the premium due date during which premium payment may be made.

HOSPITAL OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing your disability.

INJURY means:
- for purposes of Portability, a bodily injury that is the direct result of an accident and not related to any other cause.
- for all other purposes, a bodily injury that is the direct result of an accident and not related to any other cause. Disability must begin while you are covered under the plan.

INSURED means any person covered under a plan.

LAYOFF or LEAVE OF ABSENCE means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

LIFE THREATENING CONDITION is a critical health condition that possibly could result in your dependent’s loss of life.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the Summary of Benefits.

PHYSICIAN means:
- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.
Unum will not recognize you, or your spouse, children, parents or siblings as a physician for a claim that you send to us.

**PLAN** means a line of coverage under the Summary of Benefits.

**REGULAR CARE** means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

**RETAINED ASSET ACCOUNT** is an interest bearing account established through an intermediary bank in the name of you or your beneficiary, as owner.

**SICKNESS** means:

- **for purposes of Portability**, an illness, disease or symptoms for which a person, in the exercise of ordinary prudence, would have consulted a health care provider.
- **for all other purposes**, an illness or disease. Disability must begin while you are covered under the plan.

**TOTALLY DISABLED** means that, as a result of an injury, a sickness or a disorder, your dependent:

- is confined in a hospital or similar institution;
- is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness;
- is cognitively impaired; or
- has a life threatening condition.

**TRUST** means the policyholder trust named on the first page of the Summary of Benefits and all amendments to the policy.

**WAITING PERIOD** means the continuous period of time (shown in each plan) that you must be in active employment in an eligible group before you are eligible for coverage under a plan.


**YOU** means an employee who is eligible for Unum coverage.
ERISA

Additional Summary Plan Description Information

If this Summary of Benefits provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your certificate of coverage, constitute the summary plan description. The summary plan description and the Summary of Benefits constitute the Plan. Benefit determinations are controlled exclusively by the Summary of Benefits, your certificate of coverage and the information contained in this document.

Name of Plan:
Children's Friend and Service Plan

Name and Address of Employer:
Children's Friend and Service
153 Summer Street
Providence, Rhode Island
02903

Plan Identification Number:
a. Employer IRS Identification #: 05-0258819
b. Plan #: 501

Type of Welfare Plan:
Life

Type of Administration:
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance Summary of Benefits issued to the Plan.

ERISA Plan Year Ends:
December 31

Plan Administrator, Name, Address, and Telephone Number:
Children's Friend and Service
153 Summer Street
Providence, Rhode Island
02903
(401) 276-4300

Children's Friend and Service is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

Agent for Service of Legal Process on the Plan:
Children's Friend and Service
153 Summer Street
Providence, Rhode Island
02903
Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

**Funding and Contributions:**
The Plan is funded by insurance issued by Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122 (hereinafter referred to as "Unum") under identification number 395971 011. Contributions to the Plan are made as stated under "WHO PAYS FOR THE COVERAGE" in the Certificate of Coverage.

**EMPLOYER'S RIGHT TO AMEND THE PLAN**

The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of this Plan (including any related documents and underlying policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in writing and endorsed on or attached to the Plan.

**EMPLOYER'S RIGHT TO REQUEST SUMMARY OF BENEFITS CHANGE**

The Employer can request a Summary of Benefits change. Only an officer or registrar of Unum can approve a change. The change must be in writing and endorsed on or attached to the Summary of Benefits.

**MODIFYING OR CANCELLING THE SUMMARY OF BENEFITS OR A PLAN UNDER THE SUMMARY OF BENEFITS**

The Summary of Benefits or a plan under the Summary of Benefits can be cancelled:

- by Unum; or
- by the Employer.

Unum may cancel or modify the Summary of Benefits or a plan if:

- the number of employees insured is less than 10 lives or 20% of those eligible, whichever is greater; or
- the Employer does not promptly provide Unum with information that is reasonably required; or
- the Employer fails to perform any of its obligations that relate to the Summary of Benefits; or
- the premium is not paid in accordance with the provisions of the Summary of Benefits that specify whether the Employer, the employee, or both, pay the premiums; or
- the Employer does not promptly report to Unum the names of any employees who are added or deleted from the eligible group; or
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Employer and/or its employees; or
- the Employer fails to pay any portion of the premium within the 31 day grace period.
If Unum cancels or modifies the Summary of Benefits or a plan, for reasons other than the Employer's failure to pay premium, a written notice will be delivered to the Employer at least 31 days prior to the cancellation date or modification date. The Employer may cancel the Summary of Benefits or plan if the modifications are unacceptable.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify the Summary of Benefits or a plan automatically at the end of the grace period. The Employer is liable for premium for coverage during the grace period. The Employer must pay Unum all premium due for the full period each plan is in force.

The Employer may cancel the Summary of Benefits or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Employer and Unum agree, the Summary of Benefits or a plan can be cancelled on an earlier date. If Unum or the Employer cancels the Summary of Benefits or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If the Summary of Benefits or a plan is cancelled, the cancellation will not affect a payable claim.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

If a claim is based on death

In the event that your claim is denied, either in full or in part, Unum will notify you in writing within 90 days after your claim was filed. Under special circumstances, Unum is allowed an additional period of not more than 90 days (180 days in total) within which to notify you of its decision. If such an extension is required, you will receive a written notice from Unum indicating the reason for the delay and the date you may expect a final decision. Unum's notice of denial shall include:

- the specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;
- a description of any additional material or information necessary to complete the claim and why that material or information is necessary; and
- a description of the Plan's procedures and applicable time limits for appealing the determination, including a statement of your right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

If a claim is based on your disability
Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which Unum expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;
- reference specific Plan provision(s) on which the determination is based;
- describe additional material or information necessary to complete the claim and why such information is necessary;
- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and
- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

**APPEAL PROCEDURES**

**If an appeal is based on death**

If you or your authorized representative appeal a denied claim, it must be submitted within 90 days after you receive Unum's notice of denial. You have the right to:

- submit a request for review, in writing, to Unum;
- upon request and free of charge, reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations; and
- submit written comments, documents, records and other information relating to the claim to Unum.

Unum will make a full and fair review of the claim and all new information submitted whether or not presented or available at the initial determination, and may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review shall be made not later than 60 days following receipt
of the written request for review. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension and the date by which the Plan expects to make a decision. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you need to provide it to us. The 60-day extension of the appeal review period will begin after you have provided that information.

The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those Summary of Benefits' provisions upon which the final decision is based. It will also include a statement describing your access to documents and describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the determination.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

If an appeal is based on your disability

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker’s subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the
Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;
- a reference to the specific Plan provision(s) on which the determination is based;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;
- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and
- the statement that "You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

YOUR RIGHTS UNDER ERISA

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
OTHER RIGHTS

Unum, for itself and as claims fiduciary for the Plan, is entitled to legal and equitable relief to enforce its right to recover any benefit overpayments caused by your receipt of deductible sources of income from a third party. This right of recovery is enforceable even if the amount you receive from the third party is less than the actual loss suffered by you but will not exceed the benefits paid you under the Summary of Benefits. You agree that Unum and the Plan have an equitable lien over such sources of income until any benefit overpayments have been recovered in full.

DISCRETIONARY ACTS

The Plan, acting through the Plan Administrator, delegates to Unum and its affiliate Unum Group discretionary authority to make benefit determinations under the Plan. Unum and Unum Group may act directly or through their employees and agents or further delegate their authority through contracts, letters or other documentation or procedures to other affiliates, persons or entities. Benefit determinations include determining eligibility for benefits and the amount of any benefits, resolving factual disputes, and interpreting and enforcing the provisions of the Plan. All benefit determinations must be reasonable and based on the terms of the Plan and the facts and circumstances of each claim.

Once you are deemed to have exhausted your appeal rights under the Plan, you have the right to seek court review under Section 502(a) of ERISA of any benefit determinations with which you disagree. The court will determine the standard of review it will apply in evaluating those decisions.
SUMMARY

COVERAGE, LIMITATIONS AND EXCLUSIONS UNDER RHODE ISLAND LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT ("Act")

A resident of Rhode Island who purchases life insurance, annuities, long term care or accident and health insurance should know that an insurance company licensed in Rhode Island to write these types of insurance is a member of the Rhode Island Life and Health Insurance Guaranty Association ("Association"). The purpose of the Association is to assure that a policyholder will be protected within the statutory limits, if a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will, within the statutory limits, pay the claims of insured persons who live in this state, and, in some cases, keep coverage in force. However, the protection provided through the Association is not unlimited. This protection is not a substitute for your care in selecting a company that is well managed and financially stable.

LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION DISCLAIMER

The Rhode Island Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned on residence of in this state. Other conditions may also preclude coverage.

The Life and Health Insurance Guaranty Association will respond to any questions you may have which are not answered by this document. Your insurer and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy. You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association when selecting an insurer.

Rhode Island Life and Health Insurance Guaranty Association
235 Promenade Street, #426, Providence, RI 02908
Tel. (401) 273-2921

Rhode Island Division of Insurance
1511 Pontiac Avenue, Cranston, RI 02920
Tel. (401) 462-9520

The full text of the state law that provides for this safety-net coverage, Rhode Island Life and Health Insurance Guaranty Association Act, ("the Act"), can be found beginning at R.I. Gen. Laws §27-34.3-3. A brief summary of the Act is provided below. This summary does not cover all provisions of the law, nor does it in any way change your rights or obligations or those of the Association under the Act.

COVERAGES: Generally, individuals will be protected by the Association if the individual lives in Rhode Island and: Holds a life or health insurance contract, long term care
contract or annuity contract; or is insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live elsewhere.

EXCLUSIONS FROM COVERAGE: The Association does NOT protect a person holding a policy if:

- the individual is eligible for protection under a similar law of another state;
- the insurer was not authorized to do business in this state;
- the policy is issued by an organization that is not a member of the Association;
- the policy was issued by a nonprofit hospital or medical service organization (such as, the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments or by an insurance exchange.

The Association does NOT provide coverage for:

- a policy or portion of a policy not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- a policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed a rate specified by statute;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- an employer’s plan to the extent that it is self-funded (that is, not insured by an insurance company, even if an insurance company administers the plan);
- an unallocated annuity contract issued to an employee benefit plan protected under the United States Pension Benefit Guaranty Corporation;
- that part of an unallocated annuity contract not issued to a specific employee, union, association of natural persons benefit plan, or a government lottery;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the insurer;
- any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law;
- an obligation that does not arise under the express written terms of the policy or contract issued by the insurer.
- a policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code (commonly known as Medicare Part C & D) or any regulations issued pursuant thereto.
LIMITATIONS ON COVERAGE: The Act limits the amount the Association is obligated to pay. The Association cannot pay more than what the insurer would have owed under a policy or contract. Also, for any one insured life, no matter how many policies or contracts were in force with the same insurer, the Association will pay no more than:

- $300,000 in net life insurance death benefits and no more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

- $100,000 for health insurance benefits, coverages not defined as disability, basic hospital, medical, and surgical, major medical insurance, or long term care insurance including any net cash surrender and net cash withdrawal values;

- $300,000 for disability insurance;

- $300,000 for long term care insurance;

- $500,000 for basic hospital, medical, and surgical or major medical insurance;

- $250,000 in present value of annuity benefits, including net cash surrender and net cash withdrawal value;

- $250,000 in present value per payee with respect to a structured settlement annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;

- $250,000, in the aggregate, in present value of annuity benefits, including net cash surrender and net cash withdrawal values, with respect to an individual participating in a governmental retirement plan established under 26 U.S.C. §§401, 403(b), or 457 and covered by an unallocated annuity contract, or the beneficiaries of the each such individual if the individual is deceased;

- $5,000,000 in unallocated annuity contract benefits, irrespective of the number of contracts, with respect to the contract owner or plan sponsor whose plan owns, directly or in trust, one or more unallocated annuity contracts.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the Act: for unallocated annuities that fund government retirement plans under sections 401(k), 403(b), or 457 of the Internal Revenue Code, the limit is $250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the Association be liable to spend more than $300,000 in the aggregate per individual except hospital insurance up to $500,000 per individual. For covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases the contract limits also apply.

These general statements as to Limitations on Coverage are only summaries of the law. The actual limitations are set forth in R.I. Gen. Laws §27-34.3-3.

All alleged violations of the provisions of the Rhode Island Life and Health Insurance Guaranty Association Act may be reported to the Rhode Island Division of Insurance at the address and telephone number above.
This information is provided by: The Association and by the Division of Insurance, whose respective addresses are provided in the Disclaimer, above.
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CHILDREN'S FRIEND & SERVICE

WRAP PLAN DOCUMENT

Children's Friend and Service (the “Employer”) hereby adopts the Children's Friend & Service (the 'Plan'), effective as of January 01, 2021.

ARTICLE I

Purpose

The purpose of the Plan is to provide to Participants, and their Spouses, Dependents, and Beneficiaries certain welfare benefits described herein. Notwithstanding the number and types of benefits incorporated hereunder, the Plan is, and shall be treated as, a single welfare benefit plan to the extent permitted under ERISA. The Plan is intended to meet all applicable requirements of ERISA and the Code as amended, together with rulings and regulations promulgated thereunder.

ARTICLE II

Definitions

2.1 “ACA” means the Patient Protection and Affordable Care Act of 2010, as amended.

2.2 “Beneficiary” means a beneficiary as defined under a Welfare Program, which may include domestic partners.

2.3 “Code” means the Internal Revenue Code of 1986, as amended from time to time.

2.4 “Dependent” means dependent as defined under a Welfare Program. However, for purposes of any group health plan listed in Appendix A that provides medical benefits (other than a retiree medical plan) and other Welfare Programs that provide medical benefits, a Dependent shall include a Participant’s eligible children who have not attained age 26 (or such later age as determined by the Plan Administrator) and, for Grandfathered Plans, prior to Plan Years beginning before January 1, 2014, who are not eligible to enroll in another employer’s medical plan, other than the medical plan of a parent.

2.5 “Effective Date” means January 01, 2021.

2.6 “Employee” means any person providing services to the Employer or a Participating Employer as a common-law employee. To the extent permitted by law, independent contractors (even if re-characterized by the Internal Revenue Service as employees), leased employees within the meaning of Section 414(n) of the Code, and individuals designated by the Employer or Participating Employer as temporary employees shall not be Employees for purposes of this Plan. For purposes of any group health plan incorporated herein, the term
Employee shall include any variable hour, temporary or seasonal employees defined as a full-time employee under the ACA.

2.7 “Employer” means Children's Friend and Service, and any entity which succeeds to the business and assumes the obligations of the Employer hereunder.


2.9 “Former Employee” means any person formerly employed as an Employee.

2.10 “Grandfathered Plan” means the term as it is defined in the Department of Labor Regulations, 29 C.F.R. § 2590.715-1251.

2.11 “Leave of Absence” means a personal leave, medical leave or military leave, as approved by the Employer.

2.12 “Participant” means any Employee or Former Employee who satisfies the requirements of Article III of the Plan, has chosen to participate in the Plan and whose participation has not terminated in accordance with Section 3.3.

2.13 “Participant Contribution” means the pre-tax or after-tax contribution required to be paid by a Participant, if any, as determined under each Welfare Program. The term “Participant Contribution” includes contributions used for the provision of benefits under a self-insured arrangement of the Employer as well as contributions used to purchase insurance contracts or policies.

2.14 “Participating Employer” means any member of the following group including the Employer, if such member adopts the Plan with the Employer’s authorization as provided in Section 10.1: (i) a controlled group of corporations, within the meaning of Section 414(b) of the Code; (ii) a group of trades or businesses under common control, within the meaning of Section 414(c) of the Code; (iii) an affiliated service group, within the meaning of Section 414(m) of the Code; or (iv) a trade or business required to be aggregated pursuant to Section 414(o) of the Code. Each Participating Employer is identified in Appendix B. The Employer shall amend Appendix B as needed, to reflect a Participating Employer’s adoption of the Plan or withdrawal from the Plan, without any need to otherwise amend the Plan. Amendment of Appendix B may be made by any authorized officer or representative of the Employer and shall not require approval of the Board of Directors.

2.15 “Plan” means the Children's Friend & Service, as set forth herein and each Welfare Program incorporated hereunder by reference, as amended from time to time.

2.16 “Plan Administrator” means the Employer or such other individual, committee or firm as the Employer shall designate from time to time.
2.17 “Plan Year” means the twelve consecutive month period ending on December 31.

2.18 “Spouse” means a spouse as defined under a Welfare Program. Notwithstanding anything to the contrary contained herein, the term “Spouse” shall include a same-sex spouse who is legally married under applicable law.

2.19 “Welfare Program” means a written arrangement incorporated into this Plan that is offered by the Employer which provides an employee benefit, including those that would be treated as an “employee welfare benefit plan” under Section 3(l) of ERISA if offered separately. Welfare Program also means any plan established pursuant to Section 125 or Section 132(f) of the Code. Each Welfare Program under the Plan is identified in Appendix A which is incorporated into and a part of the Plan. The documents for each Welfare Program are incorporated into this document. The Employer may add or delete a Welfare Program from the Plan by amending Appendix A, without any need to otherwise amend the Plan. Amendment of Appendix A may be made by any authorized officer or representative of the Employer and shall not require approval by the Employer’s Board of Directors.

In the event that the provisions of any Welfare Program conflict with or contradict the provisions of this document or any other Welfare Program, the Plan Administrator shall use its discretion to interpret the terms and purpose of the Plan, including the written terms and provisions of any Welfare Program document, so as to resolve any conflict or contradiction. However, the terms of this document may not enlarge the rights of a Participant, Spouse, Dependent or Beneficiary to benefits available under any Welfare Program.

ARTICLE III

Eligibility and Participation

3.1 Eligibility. (a) An Employee shall be eligible to participate in the Plan only as specified in a particular Welfare Program listed in Appendix A. An eligible Employee does not include any individual who is in a division, department, unit, or job classification designated by the Employer as not benefit-eligible, regardless of the Employee’s work schedule or number of hours worked, unless the Employee is included in the employer shared responsibility penalty calculations, as defined under the ACA, and the Plan Administrator elects to include such Employees as Eligible Employees. The Welfare Program may also designate those Spouses, Dependents, Domestic Partners or Beneficiaries, if any, eligible to receive benefits from the Plan and set forth the criteria for their becoming covered hereunder.

(b) If the Employer has the equivalent of 50 or more full-time Employees, to the extent required by the ACA and other applicable federal law, an Employee shall be eligible to participate in the Employer’s group health plan if, in addition to meeting other applicable criteria, the Employee is a full-time Employee who is employed an average of at least 30 hours of service per week with the Employer.
Full-time Employee status for group health plan coverage purposes will be determined in accordance with the measurement rules as specified by the federal government and as adopted by the Employer for all Employees (including variable hour, temporary and seasonal employees, if such classes exist within the Employer). Full-time Employee status does not include any temporary employee who is eligible for group health plan coverage through a leasing organization, unless otherwise required by the ACA and the Employer. Determination of full-time Employee status will be made by the Plan Administrator, in its sole and absolute discretion, in accordance with the Plan and the Employer Shared Responsibility provisions of the ACA.

3.2 **Enrollment.** The Plan Administrator shall establish procedures in accordance with the Welfare Programs for the enrollment of eligible Employees, their Spouses or Dependents, if any, under the Plan. The Plan Administrator shall prescribe enrollment forms that must be completed by a prescribed deadline prior to commencement of coverage under the Plan.

3.3 **Termination of Participation.** A Participant shall cease being a Participant in the Plan and coverage under this Plan for the Participant, his or her Spouse, Dependents and Beneficiaries, if any, shall terminate in accordance with the provisions of the Welfare Programs and the ACA.

**ARTICLE IV**

**Funding and Benefits**

4.1 **Funding.** (a) Notwithstanding anything to the contrary contained herein, participation in the Plan and the payment of Plan benefits attributable to Employer or Participating Employer contributions shall be conditioned on a Participant contributing to the Plan at such time and in such amounts as the Plan Administrator shall establish from time to time (“Participant Contribution”). The Plan Administrator may require that any Participant Contributions be made by payroll deduction. Nothing herein requires the Employer, Participating Employer or the Plan Administrator to contribute to or under any Welfare Program, or to maintain any fund or segregate any amount for the benefit of any Participant, Spouse, Dependent, Domestic Partner or Beneficiary, except to the extent specifically required under the terms of a Welfare Program. No Participant, Spouse, Dependent, Domestic Partner or Beneficiary shall have any right to, or interest in, the assets of the Employer or Participating Employer.

(b) The Employer shall have no obligation, but shall have the right, to insure or reinsure, or to purchase stop loss coverage with respect to any Welfare Program under this Plan. To the extent the Employer elects to purchase insurance with respect to any Welfare Program, any benefits to be provided under such Welfare Program shall be the sole responsibility of the insurer, and the Employer or Participating Employer shall have no responsibility for the payment of such benefits (except for refunding any Participant Contributions that were not remitted to the insurer). Except as otherwise permitted by rulings or regulations under ERISA, any Participant Contributions shall be remitted to the appropriate insurer, as soon as practicable.
but not later than 90 days after such contributions are made and would otherwise have been paid to Participants in cash.

4.2 Benefits. Benefits will be paid solely in the form and amount specified in the relevant Welfare Program and pursuant to the terms of such Welfare Program.

ARTICLE V

Plan Administration and Fiduciary Duties

5.1 Named Fiduciary. The Plan Administrator shall be the “named fiduciary” of the Plan, as defined in Section 402(a)(2) of ERISA, unless the Employer appoints a replacement.

5.2 Plan Administration. Except as otherwise provided in a Welfare Program:

(a) The Plan Administrator shall have sole discretion and authority to control and manage the operation and administration of the Plan.

(b) The Plan Administrator shall have complete discretion to interpret the provisions of the Plan, make findings of fact, correct errors, and supply omissions. All decisions and interpretations of the Plan Administrator made in good faith pursuant to the Plan shall be final, conclusive and binding on all persons, subject only to the claims procedure, and may not be overturned unless found by a court to be arbitrary and capricious.

(c) The Plan Administrator shall have all other powers necessary or desirable to administer the Plan, including, but not limited to, the following:

(i) To prescribe procedures to be followed by Participants in making elections under the Plan and in filing claims under the Plan;

(ii) To prepare and distribute information explaining the Plan to Participants;

(iii) To receive from the Employer (or Participating Employer) and Participants, Spouses, Dependents and Beneficiaries such information as shall be necessary for the proper administration of the Plan;

(iv) To keep records of elections, claims, disbursements for claims under the Plan, and any other information required by ERISA or the Code;

(v) To appoint individuals or committees to assist in the administration of the Plan and to engage any other agents it deems advisable;

(vi) To purchase any insurance deemed necessary for providing benefits under the Plan;
(vii) To accept, modify or reject Participant elections under the Plan;

(viii) To promulgate election forms and claims forms to be used by Participants;

(ix) To prepare and file any reports or returns with respect to the Plan required by the Code, ERISA or any other laws;

(x) To determine and announce any Participant Contributions required hereunder;

(xi) To determine and enforce any limits on benefits elected hereunder;

(xii) To take such action as may be necessary to cause any required payroll deduction of any Participant Contributions required hereunder; and

(xiii) To correct errors and make equitable adjustments for mistakes made in the administration of the Plan; specifically, and without limitation, to recover erroneous overpayments made from the Plan to a Participant, Spouse, Dependent or Beneficiary, in whatever manner the Plan Administrator determines is appropriate, including recoupment of past payments, or offsets against, future payments due that Participant, Spouse, Dependent or Beneficiary.

(d) The Plan Administrator shall have sole discretion and authority regarding the distribution, or other use, of dividends, demutualization and/or the Medical Loss Ratio rebates, if any, from group health insurers.

5.3 Delegation of Duties. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan, may designate fiduciaries other than those named in the Plan, and may allocate or reallocate fiduciary responsibilities under the Plan.

5.4 Indemnification. The Plan Administrator and any delegate who is an employee of the Employer or Participating Employer shall be fully indemnified by the Employer and each Participating Employer against all liabilities, costs, and expenses (including defense costs, but excluding any amount representing a settlement unless such settlement is approved by the Employer) imposed upon it in connection with any action, suit, or proceeding to which it may be a party by reason of being the Plan Administrator or having been assigned or delegated any of the powers or duties of the Plan Administrator, and arising out of any act, or failure to act, that constitutes or is alleged to constitute a breach of such person’s responsibilities in connection with the Plan, unless such act or failure to act is determined to be due to gross negligence or willful misconduct.

5.5 Fiduciary Duties and Responsibilities. Each Plan fiduciary shall discharge his or her duties with respect to the Plan solely in the interest of each Participant, Spouse, Dependent
and Beneficiary; for the exclusive purpose of providing benefits to such individuals and defraying reasonable expenses of administering the Plan; and in accordance with the terms of the Plan. Each fiduciary, in carrying out such duties, shall act with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in exercising such authority. A fiduciary may serve in more than one fiduciary capacity. Unless liability is otherwise provided under Section 405 of ERISA, a named fiduciary shall not be liable for any act or omission of any other party to the extent that (a) such responsibility was properly allocated to such other party as a named fiduciary, or (b) such other party has been properly designated to carry out such responsibility pursuant to the procedures set forth above.

ARTICLE VI

Claims and Subrogation

6.1 Claims Procedure. Except as provided in Sections 6.2, 6.3 and 6.4, a claim for benefits under a Welfare Program shall be submitted in accordance with and to the party designated under the terms of such Welfare Program.

6.2 Claims Procedures for Group Health Plans. (a) This Section is intended to comply with Department of Labor Regulations, 29 C.F.R. §§ 2560.503-1 and 2590.715-2719, and shall apply specifically to claims under a group health plan as defined in Department of Labor Regulation 29 C.F.R. § 2560.503-1. To the extent that this procedure is inconsistent with the claims procedure contained in the policies, contracts, summary plan descriptions or other written materials for the Welfare Program, the claims procedure in such other policies, contracts, summary plan descriptions, or other written materials shall supersede this procedure, provided such other claims procedure complies with Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719. In accordance with those regulations, all claims and appeals for group health plan benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Notwithstanding any provision of this Article VI, a group health plan that is a Grandfathered Plan is not subject to the claims and appeals procedures under Department of Labor Regulation § 2590.715-2719.

(b) Written Claim for Benefits. If a claimant asserts a right to any benefit under the Plan, the claimant must file a written claim for such benefit with the Plan Administrator (as defined in Section 2.16 of this plan document). For purposes of this Section, claimant shall mean any Participant, Spouse, Dependent, or Beneficiary or authorized representative who files a claim for group health plan benefits under the Plan.
(c) Benefit Determinations. All adverse benefit determinations referenced below shall be written in a culturally and linguistically appropriate manner, and shall include the information required by Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719.

(i) Post-Service Claims. A post-service claim is any claim that is filed for payment of benefits after health care has been received.

(A) Upon the denial of a post-service claim, the Plan Administrator shall notify the claimant in writing of such denial within 30 days of receipt of the claim. The Plan Administrator shall be permitted one 15-day extension to the 30-day claim determination period, provided that the Plan Administrator determines that such extension is necessary due to matters beyond the Plan’s control and notifies the claimant before the end of the initial 30-day period of the circumstances necessitating the extension of time and the date by which the Plan intends to render a decision. If such extension is required due to the claimant’s failure to submit all information necessary to decide the claim, the extension notification must specifically describe the required information and the claimant shall have 45 days from receipt of the notice to provide the requested information. Failure by the claimant to provide requested information shall result in the denial of the claim.

(B) A denial notice shall explain the reason(s) for denial, refer to the Section(s) of the Plan on which the denial is based, and provide the claim appeal procedures. The denial notice must also comply with any additional requirements described in Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719.

(C) The time period to consider a post-service claim shall be suspended from the date any notification of extension is sent to the claimant until the claimant fulfills any request for additional information.

(ii) Pre-Service Claims. A pre-service claim is any claim for benefits that requires certification or approval prior to the performance of the requested health care service.

(A) Upon receiving a pre-service claim, the Plan Administrator shall notify the claimant in writing of the Plan’s benefit determination within a reasonable period but no later than 15 days after receipt of the claim. The Plan Administrator shall be permitted one 15-day extension provided that the Plan Administrator determines that such extension is necessary due to matters beyond the Plan Administrator’s control and notifies the claimant before the end of the initial 15-day period of the
circumstances necessitating the extension of time and the date by which the Plan intends to render a decision. The Plan Administrator shall, within 5 days of receiving any deficient claim, notify the claimant of such deficiency and the steps necessary to correct the claim. Notification may be oral unless the claimant requests written notification. The claimant shall have 45 days from receipt of the notice to provide the requested information. Failure by the claimant to provide requested information shall result in the denial of the claim.

(B) A denial notice shall explain the reason(s) for the denial, refer to the Section(s) of the Plan on which the denial is based, and provide the claim appeal procedures. The denial notice must also comply with any additional requirements described in Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719.

(C) The time period to consider a pre-service claim shall be suspended from the date any notification of extension is sent to the claimant until the claimant fulfills any request for additional information.

(iii) Urgent Care Claims. An urgent care claim is a claim that requires notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize the claimant’s life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of the claimant’s health condition, could cause severe pain.

(A) An urgent care claimant shall receive notice of the benefit determination in writing or electronically as soon as possible, but no later than 72 hours (or such other time as prescribed in Department of Labor Regulations) after the Plan Administrator receives all necessary information, taking into account the severity of the claimant’s condition. Notice of denial may be oral with a written or electronic confirmation to follow within 3 days. If the claimant files an urgent care claim improperly, the Plan Administrator, within 24 hours after the claim is received, shall notify the claimant of the improper filing and how to correct it. The claimant shall have 48 hours (or such other time as prescribed in Department of Labor Regulations) to provide the requested information and shall be notified of a determination no later than 48 hours after receipt of the corrected claim or the end of the 48-hour period afforded to the claimant to provide the requested additional information.

(B) A denial notice shall explain the reason(s) for the denial, refer to the Section(s) of the Plan on which the denial is based, and provide the claim appeal procedures. The denial notice must also comply
with any additional requirements described in Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719.

(iv) Concurrent Care Claims.

(A) Any request by a claimant to extend an on-going course of treatment beyond a previously approved specified period of time or number of treatments, that is an urgent care claim as defined in paragraph (iii), shall be decided as soon as possible, and the Plan Administrator shall notify the claimant of the determination within 24 hours of receipt of the claim, provided the claim is made at least 24 hours prior to the end of the approved period of time or number of treatments. If the claimant’s request for extended urgent care treatment is not made at least 24 hours prior to the end of the approved treatment, the request shall be treated as an urgent care claim in accordance with paragraph (iii).

(B) If an on-going course of treatment was previously approved for a specified period of time or number of treatments, and the claimant’s request to extend treatment is non-urgent, the claimant’s request shall be considered a new claim and decided in accordance with post-service or pre-service timeframes, as applicable.

(d) Appeal of Claim Denial.

(i) Any claimant shall have the right to appeal an “adverse benefit determination” as defined in Department of Labor Regulation 29 C.F.R. § 2590.715-2719 within 180 days of receipt of such adverse benefit determination. Any appeal shall be submitted to the Plan Administrator in writing. If the appeal relates to a claim for payment, the claimant’s request should include: the patient’s name and plan identification number; the date(s) of health care service(s); the provider’s name; the reason(s) the claimant believes the claim should be paid; and any documentation or other written information to support the claimant’s request for claim payment.

(ii) An appeal shall be determined by an individual who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor a subordinate of that individual. If the appeal is related to medical matters, the appeal shall be reviewed in consultation with an independent and impartial health care professional who has appropriate training and experience in the particular field of medicine in order to make the health care judgment and who was not involved in the prior determination. The Plan Administrator may consult with, or seek the participation of, independent and impartial medical experts as part of the appeal resolution process. The claimant consents to this referral and the sharing of pertinent health claim information. The claimant shall have the right to review and respond to any new or additional evidence or rationales considered, relied upon, or generated by the Plan or other person making the benefit determination before the Plan issues an adverse benefit determination on appeal. Upon request and free of charge the claimant has the right to
reasonable access to and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits.

(iii) The claimant shall be notified of the Plan Administrator’s decision upon review as appropriate, in accordance with the content and timing requirements of Department of Labor Regulations, 29 C.F.R. §§ 2560.503-1 and 2590.715-2719.

(iv) Upon being notified of an adverse determination under an appeal, the claimant shall be permitted, within 60 days of receiving notice of such determination, to submit notice of a “second-level appeal” to the Plan Administrator. A second-level appeal shall be decided in accordance with the rules in paragraph (ii).

(e) Timeframes for Appeals Determinations.

(i) Pre-Service Claim Appeal. The Plan Administrator shall have 15 days, upon receiving notice of appeal (or second-level appeal) of the denial of benefits under a pre-service claim, to notify the claimant electronically or in writing of the appeal determination.

(ii) Post-Service Claim Appeal. The Plan Administrator shall have 30 days, upon receiving notice of appeal (or second-level appeal) of the denial of benefits under a post-service claim, to notify the claimant electronically or in writing of the appeal determination.

(iii) Urgent Care Claim Appeal. Upon receiving a notice to appeal (or second-level appeal) the determination of a claim involving urgent care, the Plan Administrator shall notify the claimant of the appeal determination as soon as possible, taking into account medical exigencies surrounding the claim, but no later than 72 hours (or such other time as prescribed in Department of Labor Regulations). Notice shall be given to the claimant by telephone, facsimile, or other similarly expeditious manner. Oral communications shall be followed up in writing.

(iv) The Plan Administrator has the exclusive right to interpret and administer the provisions of the Plan and its decisions with respect to claims are conclusive and binding.

(f) External Appeals. Except as otherwise required by applicable law, if a Participant exhausts all internal appeals procedures, the Participant may commence an external review. The external review process will comply with applicable state or federal law and other rules and procedures for non-Grandfathered Plans as prescribed in Department of Labor Regulation 29 C.F.R. § 2590.715-2719.

6.3 Claims Procedure for Benefits Based on Determination of Disability. (a) This Section shall apply to any claim made under a Welfare Program which bases benefits on a determination of disability. To the extent that this procedure is inconsistent with the claims procedure contained in the policies, contracts, summary plan descriptions or other written materials for the Welfare Program, the claims procedure in such other policies, contracts,
summary plan descriptions, or other written materials shall supersede this procedure as long as such other claims procedure complies with Department of Labor Regulation 29 C.F.R. § 2560.503-1. In accordance with that regulation, all claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.

(b) If a claim for benefits based on a determination of disability is denied in whole or in part, the claimant or the claimant’s Beneficiary shall receive written notification of the “adverse benefit determination” as defined in 29 C.F.R. § 2560.503-1 in a culturally and linguistically appropriate manner. A denial notice shall explain the reason(s) for the denial, refer to the Section(s) of the Plan on which the denial is based, and provide the claim appeal procedures. The denial notice must also comply with any additional requirements described in Department of Labor Regulation 29 C.F.R. § 2560.503-1. Among other requirements, that regulation requires denial notices for disability claims to include:

(i) a discussion of the decision, including, if applicable, the basis for disagreeing with or not following the views of health care and vocational professionals who evaluated the claimant, the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant’s adverse benefit determination, or with a disability benefit determination regarding the claimant made by the Social Security Administration;

(ii) the internal rules, guidelines, protocols, standards, or other similar criteria of the Plan that were relied upon in denying the claim or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;

(iii) if applicable, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(iv) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits.

Claimants will receive adverse benefit determinations within a reasonable period of time, but no later than 45 days after the Plan Administrator’s receipt of the claim. The Plan Administrator may extend this period for up to 30 additional days provided the Plan Administrator determines that the extension is necessary due to matters beyond the Plan Administrator’s control and the claimant is notified of the extension before the end of the initial 45-day period and is also notified of the date by which the Plan Administrator expects to render a decision. The 30-day extension can be extended by an additional 30 days if the Plan Administrator determines that, due to matters beyond its control, it cannot make the decision within the original extended period. Any notice of extension must be sent to the claimant before the end of the initial 30-day period, and shall explain the circumstances requiring the extension, the date by which the Plan Administrator expects to render a decision, the standards on which the
claimant’s entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information, if any, the claimant must submit. The claimant shall be provided with at least 45 days to provide the additional information. The period from which the claimant is notified of the additional required information to the date the claimant responds is not counted as part of the determination period.

(c) The claimant shall have 180 days to appeal an adverse benefit determination. The claimant shall have the right to review and respond to any new or additional evidence or rationales considered, relied upon, or generated by the Plan or other person making the benefit determination before the Plan issues an adverse benefit determination on appeal. The claimant shall be notified of the Plan Administrator’s decision upon review within a reasonable period of time, but no later than 45 days after the Plan Administrator receives the claimant’s appeal request. The Plan’s adverse benefit determination on review shall include the information required by Department of Labor Regulation 29 C.F.R. § 2560.503-1. Among other requirements, this adverse benefit determination must include a statement of the claimant’s right to bring a lawsuit in federal court and a description of any applicable contractual limitations period that applies to the claimant’s right to bring a lawsuit and its expiration date.

The 45-day period may be extended for an additional 45-day period if the Plan Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time and provided that the claimant is notified of the extension prior to the expiration of the initial 45-day period. Such notice shall state the special circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision.

(d) The time period to consider a claim for benefits based on a determination of disability or to consider an appeal of an adverse benefit determination shall be suspended from the date any notification of extension is sent to the claimant or appellant until such individual fulfills such request for additional information.

6.4 Claims Procedure for Benefits Other Than Health Benefits or Those Based on Determination of Disability.

(a) If the Welfare Program does not describe a claims procedure for benefits that satisfies the requirements of Section 503 of ERISA, or the Plan Administrator determines that the procedures described in Sections 6.2 or 6.3 with respect to a particular Welfare Program shall not apply, the claims procedure described in this Section shall apply with respect to such Welfare Program if the Welfare Program is subject to ERISA. If the Welfare Program is not subject to ERISA as determined by the Plan Administrator, then the claims procedure contained in the policies, contracts, summary plan descriptions or other written materials for the Welfare Program shall supersede this procedure.

(b) If a Participant or former Participant asserts a right to any benefit under the Plan that the Participant has not received, the Participant or his or her authorized representative shall file a written claim for such benefit with the Plan Administrator. If the Plan Administrator wholly or partially denies such claim, it shall provide written or electronic notice to the claimant.
within a reasonable period of time, but not later than 90 days after receipt by the Plan Administrator of the claim, unless the Plan Administrator determines that special circumstances require an extension of time, not to exceed 90 days, for processing the claim. If the Plan Administrator determines that an extension of time is required, it shall provide the claimant with written notice of the extension before the end of the initial 90-day period. Such notice shall describe the special circumstances requiring the extension of time and specify the date by which the Plan Administrator expects to render a benefit determination. If the Plan Administrator wholly or partially denies a claim, it shall set forth in its benefit determination, which shall be written in a manner calculated to be understood by the claimant:

(i) the specific reasons for the denial of the claim;

(ii) specific reference(s) to pertinent provisions of the Plan on which the adverse benefit determination is based;

(iii) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;

(iv) an explanation of the Plan’s claims review procedure, including the time limits applicable under such procedure; and

(v) a statement that the claimant has the right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

(c) A Participant or former Participant whose claim for benefits is denied may request a full and fair review of the adverse benefit determination within 60 days after notification of the adverse benefit determination by the Plan Administrator. The Participant or former Participant:

(i) shall be provided a review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial determination;

(ii) shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim; and

(iii) may submit written comments, documents, records and other information relating to the claim to the Plan Administrator for review.

(d) Subject to Department of Labor Regulation 29 C.F.R. § 2560.503-1(i)(1)(ii), a decision on review by the Plan Administrator shall be made within a reasonable period of time, but not later than 60 days after receipt by the Plan Administrator of a request for review, unless special circumstances (such as the need to hold a hearing) require an extension of time for processing, in which case the claimant shall be provided with written notice of the extension before the end of the initial 60-day period. Such notice shall describe the special
circumstances requiring the extension and specify the date by which the Plan Administrator expects to render its decision. In no event shall the decision be rendered later than 120 days after receipt of the request for review.

(e) The Plan Administrator shall provide written or electronic notice of its decision with respect to the claimant’s appeal which shall be written in a manner calculated to be understood by the claimant. If there is an adverse benefit determination on review, the Plan Administrator’s decision shall include:

(i) the specific reasons for the adverse benefit determination;

(ii) specific reference(s) to pertinent provisions of the Plan on which the adverse benefit determination is based;

(iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim;

(iv) a statement describing any voluntary appeal procedures offered by the Plan and the claimant’s right to receive information about any such procedures; and

(v) a statement that the claimant has the right to bring a civil action under Section 502(a) of ERISA following the adverse benefit determination on review.

6.5 Unclaimed Benefits. If, within one year after any amount becomes payable hereunder to a Participant, Spouse, Dependent or Beneficiary and the same shall not have been claimed or any check issued under the Plan remains uncashed, provided reasonable care shall have been exercised by the Plan Administrator in attempting to make such payments, the amount thereof shall be forfeited and shall cease to be a liability of the Plan.

6.6 Right of Subrogation.

(a) Definitions. For purposes of this Section, the following definitions shall apply:

(i) Award. “Award” means any amount paid to or on behalf of a Covered Individual, from a Third Party with respect to a Covered Individual’s Illness, Injury or other loss regardless of whether such amount is received as a result of a judgment of a court of competent jurisdiction, settlement, compromise or otherwise and regardless of whether such amount is categorized as punitive, compensatory, reimbursement for medical expenses, or otherwise.

(ii) Covered Individual. “Covered Individual” includes the individual for whom benefits are paid by the Plan and his or her heirs, guardians, executors or other representatives.
(iii) Injury or Illness. “Injury” or “Illness” means such term as defined in each Welfare Program.

(iv) Reimbursement. “Reimbursement” means the Plan’s right to recover any and all amounts paid for medical expenses from a Covered Individual who receives any award related to the Illness, Injury or other loss that resulted in the payment of such benefits by the Plan.

(v) Subrogation. “Subrogation” means the right of the Plan to be substituted in place of any Covered Individual with respect to that Covered Individual’s lawful claim, demand, or right of action against a Third Party who may have wrongfully caused the Covered Individual’s Injury, Illness or other loss that resulted in a payment of benefits by the Plan.

(vi) Third Party. “Third Party” includes, but is not limited to, any person or entity that caused, contributed to, or may be responsible for the Injury, Illness or other loss to the Covered Individual. Third Party shall include any party, such as an insurance company, that acquires or may acquire responsibility through the actions of such person or entity, and shall also include uninsured motorist coverage.

(b) Subrogation, Reimbursement and Benefit Offsets. For any and all benefits paid by the Plan to or on behalf of a Covered Individual by reason of Illness, Injury or other loss, the Plan shall have the following rights:

(i) Subrogation to any and all rights of recovery the Covered Individual may have arising from such Injury, Illness or other loss;

(ii) Reimbursement for the amount of any and all benefits paid to or on behalf of the Covered Individual by reason of Injury, Illness or other loss with respect to which the Plan has a right to Subrogation pursuant to paragraph (i) above from any Award arising out of such Injury, Illness or other loss; and

(iii) Benefit offsets of future claims payable by the Plan on behalf of the Covered Individual or members of such Covered Individual’s immediate family to recover any and all amounts paid to or on behalf of the Covered Individual by reason of such Illness, Injury or other loss with respect to which the Plan has a right to Subrogation pursuant to paragraph (i) and a right to Reimbursement pursuant to paragraph (ii) but which have not, for any reason whatsoever, been reimbursed to or recovered by the Plan.

The Plan’s subrogation/reimbursement/benefit offset rights (herein referred to collectively as “Recovery Rights”) shall include the right to recover the amount due and owing to the Plan pursuant to its Recovery Rights from any Award paid to or for the benefit of the Covered Individual. The Plan does not recognize the “make whole” rule and a Covered Individual may not be whole after the Plan’s Recovery Rights are satisfied.
(c) Payment Prior to Determination of Responsibility of a Third Party. The Plan does not cover nor is it liable for any expenses for services or supplies incurred by a Covered Individual for any Illness, Injury or other loss which a Third Party caused, contributed to or may be responsible for to the extent that the Covered Individual receives any Award from any Third Party. However, subject to the terms and conditions of this Section, the Plan will, after receipt of an executed reimbursement/subrogation/assignment agreement on such form as the Plan Administrator may require, make advance payment of benefits in accordance with the terms of the Plan, until an Award is paid to or for the benefit of the Covered Individual by a Third Party with respect to such Illness, Injury or loss. The terms and provisions of such reimbursement/subrogation/assignment agreement are incorporated herein by reference and any such agreement shall constitute a part of the Plan.

By accepting an advance payment of benefits from the Plan, the Covered Individual(s) jointly and severally agree that:

(i) the Plan has a priority lien against any Award paid to or on behalf of the Covered Individual to assure that Reimbursement is promptly made; and

(ii) the Plan will be subrogated to such Covered Individual’s right of recovery from any Third Party to the extent of the Plan’s advance payment of benefits; and

(iii) such Covered Individual(s) will, jointly and severally, reimburse the Plan out of any and all Awards paid or payable to such Covered Individual(s) by any Third Party to the extent of the Plan’s advance payment of benefits for claims related to the Illness, Injury or other loss; and

(iv) such Covered Individual(s) will assign to the Plan all of their right, title and interest in and to any Award paid to or on their behalf by any Third Party to the extent of any advance payment of benefits made or to be made in accordance with the terms of the Plan.

The Plan’s Recovery Rights include but are not limited to all claims, demands, actions and rights of recovery of all Covered Individuals against any Third Party, including any workers’ compensation insurer or governmental agency, and will apply to the extent of any and all advance payment of benefits made or to be made by the Plan.

(d) Recovery Actions. The Plan may, at its discretion, start any legal action or administrative proceeding it deems necessary to protect its Recovery Rights, and may try or settle any such action or proceeding in the name of and with the full cooperation of the Covered Individual. However, in doing so, the Plan will not represent, or provide legal representation for, any Covered Individual with respect to such Covered Individual’s damages to the extent those damages exceed any advance payment of benefits made or to be made in accordance with the terms of this Plan.
The Plan may, at its discretion, intervene in any claim, legal action, or administrative proceeding started by any Covered Individual against any Third Party on account of any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the Covered Individual’s Illness, Injury or other loss that resulted in any advance payment of benefits by the Plan.

(e) Reimbursement/Subrogation/Assignment Agreement. Prior to the advance payment of benefits for which a Third Party may be responsible, the Covered Individual on whose behalf an advance payment of benefits may be payable must execute and deliver any and all agreements, instruments and papers requested by or on behalf of the Plan including an executed reimbursement/subrogation/assignment agreement or such other form as the Plan Administrator may require. The failure of a Covered Individual to execute any such reimbursement/subrogation/assignment agreement or such other form as the Plan Administrator may require, for any reason, shall not waive, compromise, diminish, release, or otherwise prejudice any of the Plan’s Recovery Rights if the Plan, at its discretion, makes an advance payment of benefits for any reason in the absence of a reimbursement/subrogation/assignment agreement.

(f) Administrative Procedure. The Plan’s standard administrative procedure will be to determine whether a Third Party could be held liable for a claim. Claims will not be paid until this determination is made. If it is determined that the claim may be the responsibility of a Third Party for any reason, the Plan will not process any claims without a properly signed reimbursement/subrogation/assignment agreement as described in this Section.

(g) Cooperation with the Plan by All Covered Individuals. By accepting an advance payment of benefits, the Covered Individual agrees not to do anything that will waive, compromise, diminish, release or otherwise prejudice the Plan’s Recovery Rights and to do whatever is necessary to protect the Plan’s Recovery Rights.

By accepting an advance payment for benefits the Covered Individual agrees to notify and consult with the Plan Administrator or its designee before:

(i) starting any legal action or administrative proceeding against a Third Party based on any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the Covered Individual’s Illness, Injury or other loss that resulted in the Plan’s advance payment for benefits; or

(ii) entering into any settlement agreement with a Third Party that may be related to any actions by the Third Party that may have caused or contributed to the Covered Individual’s Illness, Injury or other loss that resulted in the Plan’s advance payment for benefits related to such Illness, Injury or other loss.

Furthermore, by accepting an advance payment of benefits, the Covered Individual agrees to keep the Plan Administrator or its designee informed of all material developments with respect to all such claims, actions or proceedings.
The Plan’s Recovery Rights are Plan assets. The Plan or its designee may institute a lawsuit against a Covered Individual if such Covered Individual does not adequately protect the Plan’s Recovery Rights.

(h) **All Recovered Proceeds Are to be Applied to Reimburse the Plan.** By accepting an advance payment of benefits for an Illness, Injury or other loss, the Covered Individual agrees to reimburse the Plan for all such advances from any Award paid or payable to or on behalf of such Covered Individual by any Third Party. In such event, the Plan must be fully reimbursed within 31 days or the Covered Individual will be liable for interest and all costs of collection, including reasonable attorney’s fees.

If a Covered Individual fails to reimburse the Plan as required by this Section, the Plan may apply any future claims for benefits that may become payable on behalf of such Covered Individual or any member of such Covered Individual’s immediate family to the amount not reimbursed.

Notwithstanding anything contained in the Plan to the contrary, the Plan will not pay future benefits for claims related to an Illness, Injury or other loss with respect to which an Award was paid to or on behalf of a Covered Individual unless the Plan Administrator determines that the Award was reasonable and the subsequent claims were not recognized in the Award.

(i) **Pre-Emption of State Law.** To the extent that this Plan is a self-insured employee welfare benefit plan, ERISA preempts any state law purporting to limit, restrict or otherwise alter the Plan’s Recovery Rights.

(j) **No-Fault Insurance Coverage.** Notwithstanding anything contained in the Plan to the contrary, if a Covered Individual is required to have no-fault automobile insurance coverage, the automobile no-fault insurance carrier will initially be liable for any and all expenses paid by this Plan up to the greater of:

(i) the maximum amount of basic reparation benefit required by applicable law, or

(ii) the maximum amount of the applicable no-fault insurance coverage in effect.

The Plan will, thereafter, consider any excess charges and expenses under the applicable provisions of this Plan in which the Covered Individual is provided coverage. Before related claims will be paid through the Plan, the Covered Individual will be required to sign a reimbursement/subrogation/assignment agreement or such other form as the Plan Administrator may require.
If the Covered Individual fails to secure no-fault insurance as required by state law, the Covered Individual is considered as being self-insured and must pay the amount of any and all expenses paid by the Plan for any and all Covered Individuals arising out of the accident.

(k) Refund of Overpayment of Benefits – Right of Recovery. If the Plan pays benefits for expenses incurred on account of a Covered Individual, the Covered Individual or any other person or organization that was paid must make a refund to the Plan if:

(i) all or some of the expenses were not paid, or did not legally have to be paid, by the Covered Individual;

(ii) all or some of the payment made by the Plan exceeds the benefits under the Plan; or

(iii) all or some of the expenses were recovered from or paid by a source other than this Plan, including another plan to which this Plan has secondary liability under the Coordination of Benefits provisions.

This may include payments made as a result of claims against a Third Party for negligence, intentional or otherwise wrongful acts or omissions. The refund shall equal the amount the Plan paid in excess of the amount it should have paid under the Plan. In the case of recovery from or payment by a source other than this Plan, the refund equals the amount of the recovery or payment up to the amount the Plan paid.

If a Covered Individual or any person or organization that was paid does not promptly refund the full amount, the Plan may reduce the amount of any future benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

ARTICLE VII

Special Compliance Provisions

7.1 Use and Disclosure of Protected Health Information. (a) Any health plan under the Plan shall use protected health information (“PHI”) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). For purposes of this Section, health plan shall have the meaning as defined in HIPAA. Specifically, any health plan shall use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

(b) Health Care Treatment. Health care treatment means the provision, coordination or management of health care and related services by one or more health care providers. It also includes coordination or management of health care by a health provider and a third party and consultation or referrals between one health care provider and another.
(c) Payment. Payment includes activities undertaken by any health plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits, or to obtain or provide reimbursement for the provision of health care, that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

(i) determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual’s claim);

(ii) coordination of benefits;

(iii) adjudication of health claims (including appeals and other payment disputes);

(iv) subrogation of health claims;

(v) establishing employee contributions;

(vi) risk adjusting amounts due based on enrollee health status and demographic characteristics;

(vii) billing, collection activities and related health care data processing;

(viii) claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

(ix) obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(x) medical necessity reviews or reviews of appropriateness of care or justification of charges;

(xi) utilization review, including precertification, preauthorization, concurrent review and retrospective review;

(xii) disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and

(xiii) reimbursement to a health plan.
(d) **Health Care Operations.** Health care operations include, but are not limited to, the following activities:

(i) quality assessment;

(ii) 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;

(iii) rating provider and health plan performance, including accreditation, certification, licensing or credentialing activities;

(iv) underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

(v) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(vi) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the health plan, including formulary development or improvement of payment methods or coverage policies; and

(vii) business management and general administrative activities of the health plan, including, but not limited to:

(A) management activities relating to the implementation of and compliance with HIPAA’s administrative simplification requirements;

(B) customer service, including the provision of data analyses for policyholders, plan sponsors or other customers, provided that protected health information is not disclosed to such policyholder, plan sponsor, or customer;

(C) resolution of internal grievances; and

(D) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a “covered entity” under HIPAA or, following completion of the sale or transfer, will become a covered entity.

(e) A health plan will use and disclose PHI as required by law and as permitted by authorization of the Participant or other covered individual. With an authorization,
a health plan shall disclose PHI to pension plans, disability plans, reciprocal benefit plans, and
workers’ compensation insurers, for purposes related to administration of the health plan.

(f) A health plan shall disclose PHI to the Employer only upon receipt of a
certification from the Employer that the health plan documents have been amended to
incorporate the following provisions and that the Employer agrees to:

(i) not use or further disclose PHI other than as permitted or required
by the health plan document or as required by law;

(ii) ensure that any agents, including subcontractors, to whom the
Employer provides PHI received from a health plan agree to the same restrictions and conditions
that apply to the Employer with respect to such PHI;

(iii) not use or disclose PHI for employment-related actions and
decisions unless authorized by an individual;

(iv) not use or disclose PHI in connection with any other benefit or
employee benefit plan of the Employer unless authorized by an individual;

(v) report to the health plan’s designee any PHI use or disclosure that
it becomes aware of which is inconsistent with the uses or disclosures provided for;

(vi) make PHI available to an individual in accordance with HIPAA’s
access requirements;

(vii) make PHI available for amendment and incorporate any
amendments to PHI in accordance with HIPAA;

(viii) make available the information required to provide an accounting
of disclosures;

(ix) make the Employer's internal practices, books and records relating
to the use and disclosure of PHI received from the Plan available to the U.S. Department of
Health and Human Services for the purposes of determining the health plan’s compliance with
HIPAA;

(x) ensure that adequate separation between the health plan and the
Employer is established as required by HIPAA; and

(xi) if feasible, return or destroy all PHI received from the health plan
that the Employer 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 not
feasible).
(g) Only those employees or classes of employees identified in the Plan’s privacy policies and procedures may have access to and use and disclose PHI for plan administration functions that the Employer performs for the health plan. If such individuals do not comply with this health plan document, the Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

(h) Security. The Employer shall implement security measures with respect to PHI to the extent of and in accordance with the security rules implemented by HIPAA. Specifically, the Employer shall:

(i) implement administrative, physical and technical safeguards that will reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the plan;

(ii) ensure the adequate separation between the Plan and the Employer is supported by reasonable and appropriate security measures;

(iii) ensure that any agent, including a subcontractor, to whom it provides information agrees to implement reasonable and appropriate security measures to protect the information (e.g., in the event the Employer provides information to the broker for renewal bids); and

(iv) report to the Plan any security incident of which it becomes aware.

7.2 Special Enrollment Rights. (a) In accordance with the HIPAA special enrollment rules, if an eligible Employee declines coverage in a group health plan for himself or herself and/or the Employee's Spouse and Dependents because of other health insurance coverage, they may be able to enroll in the Plan’s group health coverage upon loss of eligibility for the other coverage, provided that the Participant requests enrollment within 30 days after the other coverage ends.

If a Participant gains a new Spouse or Dependent as a result of marriage, birth, adoption, or placement for adoption, he or she may be able to enroll himself or herself and the Participant's Spouse and Dependents in the group health Welfare Program provided that enrollment is requested within 30 days after the marriage, birth, adoption, or placement for adoption.

(b) Employees, Spouses and Dependents who are eligible but not enrolled in a group health plan listed in Appendix A may enroll when:

(i) The Employee’s, Spouse’s or Dependent’s Medicaid or Children’s Health Insurance Program (“CHIP”) coverage is terminated as a result of loss of eligibility and
the eligible Employee requests coverage under a group health plan listed in Appendix A within 60 days after the termination, or

(ii) The Employee, Spouse or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP and the eligible Employee requests coverage under a group health plan listed in Appendix A within 60 days after eligibility is determined.

The special enrollment rules of this Section 7.2 do not apply to limited scope dental or vision benefits or certain health care flexible spending accounts (e.g., health care spending accounts that limit benefits to employee salary reduction amounts).

7.3 Qualified Medical Child Support Orders. A qualified medical child support order (“QMCSO”) is an order made pursuant to state domestic relations law by a court or a state agency authorized under state law to issue child support orders which requires a group health plan to provide a child or children of an Employee with health insurance coverage. The Plan Administrator shall comply with the terms of any QMCSO it receives, and shall:

(a) Establish reasonable procedures to determine whether a medical child support order is a QMCSO as defined under Section 609 of ERISA (these procedures are available, free of charge, to Participants and Beneficiaries upon request to the Plan Administrator);

(b) Promptly notify the Participant and any alternate recipient of the receipt of a medical child support order, and the group health plan’s procedures for determining whether the medical child support order is a QMCSO; and

(c) Within a reasonable period of time after receipt of such order, determine whether such order is a QMCSO and notify the Participant and each alternate recipient of such determination.

7.4 State Medicaid Programs. Eligibility for coverage or enrollment in a state Medicaid Program shall not impact an Employee’s, Spouse’s or Dependent’s eligibility for health coverage or health benefits under the Plan.

7.5 Coverage During FMLA Leave. A Participant on a leave of absence that qualifies as leave under the Family and Medical Leave Act of 1993 (“FMLA”) may continue to receive group health plan coverage under this Plan during such leave along with his or her eligible Spouse and Dependents as if such participant did not experience an interruption in active employment until the end of such FMLA leave period, or, if earlier, the date the Participant gives notice that he or she does not intend to return to work at the end of the FMLA period. The Participant must make any required contributions for group health plan coverage during such period in such time and manner as the Plan Administrator may require under applicable federal regulations and in accordance with the terms of any applicable Code Section 125 cafeteria plan sponsored by the Employer.
If a Participant does not continue group health coverage or other types of coverage but returns to work before the expiration of FMLA leave, he or she must be reinstated in his or her benefit coverage, including group health care coverage, at the same level and under the same conditions as if the leave had not occurred.

7.6 Special Rules for Maternity and Infant Coverage. Any health plan available under the Plan shall 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 cesarean section. The attending provider or physician, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable). Notwithstanding the foregoing, the health plan and issuers may not require that a provider obtain authorization from the health plan or the issuer for prescribing the length of stay not in excess of 48 hours or 96 hours, as the case may be.

7.7 Special Rule for Women’s Health. If a health benefit plan available under the Plan provides medical and surgical benefits for mastectomy procedures, it shall provide coverage for reconstructive surgery following mastectomies. This expanded coverage includes reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedema. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other benefits under the health benefit plan or coverage.

7.8 Military Leave.

A Participant’s right to elect continued participation in a group health plan available under this Plan for himself or herself, the Participant's Spouse and Dependents during a leave of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (“USERRA”).

(a) Participants may elect to continue group health plan coverage under the Plan for a period of time that is the lesser of:

(i) the 24-month period beginning on the Participant’s first day of military leave, or

(ii) the period beginning on the Participant’s first day of military leave and ending on the date the Participant fails to return from military leave or apply for re-employment as required under USERRA.

(b) If a Participant’s absence for military duty is less than 31 days, the Participant will be required to pay the regular employee share of the cost for group health plan coverage. If the Participant’s absence is for 31 or more days, the Participant will be required to
pay not more than 102% of the full cost of the group health plan coverage (and the Participant's Spouse and Dependents) under the Plan.

(c) USERRA continuation group health plan coverage is considered alternative group health plan coverage for purposes of COBRA. Therefore, if a Participant elects USERRA continuation coverage, COBRA continuation group health plan coverage shall not be available.

(d) Participants returning from military leave shall be reinstated upon re-employment, and any exclusion or waiting period shall not be imposed if such exclusion or waiting period would not have been imposed had the Participant’s coverage not been terminated due to military leave. This paragraph shall not apply to illnesses or injuries determined by the Secretary of Veteran’s Affairs or his or her representative to have been incurred in, or aggravated during, the performance of military service.

(e) In no event shall benefits available under this Plan during a period of USERRA qualified military leave be less generous than those benefits available during other comparable employer approved leave periods (e.g., family and medical leave).

7.9 COBRA.

(a) Legal Rights to Continuation Coverage Under the Consolidated Omnibus Budget Reconciliation Act (“COBRA”). The Employer, to the extent required by law, shall offer a Participant and/or a Spouse or dependent child who, as a result of a "qualifying event," becomes otherwise ineligible to participate in a group health plan, as defined in Section 607(l) of ERISA, under the Plan the opportunity to temporarily extend coverage under such group health plan at group rates. A domestic partner shall not be considered a Spouse for COBRA purposes and therefore shall not be entitled to COBRA continuation coverage unless otherwise required under applicable law. However, the Employer may, solely in its own discretion, and solely in the manner it determines, provide continuation coverage to domestic partners who are Plan beneficiaries.

(b) Qualifying Events.

(i) A Participant who loses group health plan coverage or for whom premium payments or contributions for coverage increase as a result of one of the following qualifying events, shall be eligible for COBRA continuation coverage.

(A) A reduction of the Participant’s hours of employment;

(B) The Participant’s voluntary or involuntary termination of employment for reasons other than gross misconduct; or

(C) Upon the Employer’s bankruptcy petition under Title XI of the Bankruptcy Act, if the Participant is a retired employee.
(ii) A Spouse who loses group health plan coverage or for whom premium payments or contributions for coverage increase as a result of one of the following qualifying events, shall be eligible for COBRA continuation coverage.

(A) The Participant’s voluntary or involuntary termination of employment for reasons other than gross misconduct, or reduction of hours of employment;

(B) The death of the Participant;

(C) The divorce or legal separation of the Participant and Spouse;

(D) Enrollment in Medicare (Part A or B) by the Participant; or

(E) The Employer’s bankruptcy petition under Title XI of the Bankruptcy Act, if the Participant is retired.

(iii) A Participant’s dependent child who loses group health plan coverage or for whom premium payments or contributions for coverage increase as a result of one of the following events, shall be entitled to COBRA continuation coverage.

(A) The loss of Dependent status under the group health plan;

(B) The Participant’s voluntary or involuntary termination for reasons other than gross misconduct, or the Participant’s reduction of hours of employment;

(C) The death of the Participant;

(D) The divorce or legal separation of the Participant and Spouse;

(E) Enrollment in Medicare (Part A or B) by the Participant; or

(F) The Employer’s bankruptcy petition under Title XI of the Bankruptcy Act, if the Participant is retired.

(c) Qualified Beneficiary. A Qualified Beneficiary is a Participant, Spouse, or dependent child who on the day before a qualifying event is covered under a group health plan available under the Plan. Qualified Beneficiary includes children born to, adopted by, or placed for adoption with the Participant during his or her COBRA continuation coverage period. Such child’s coverage period shall be determined according to the date that the Participant’s COBRA continuation coverage period began. A domestic partner is not a Qualified Beneficiary for
COBRA purposes and therefore shall not be entitled to COBRA continuation coverage as described in this Article VII unless otherwise required under applicable law.

(d) Notices. A Qualified Beneficiary who wishes to receive COBRA continuation coverage as a result of divorce or legal separation must notify the Plan Administrator within 60 days after such divorce or legal separation. A Qualified Beneficiary who wishes to receive COBRA continuation coverage as a result of the loss of Dependent status under the group health plan available under the Plan must notify the Plan Administrator within 60 days of such loss of Dependent status.

The Qualified Beneficiary shall be notified of his or her right to elect continuation coverage and the cost to do so. Continuation coverage must be elected within 60 days after the later of the date coverage under the group health plan available under the Plan ceases or the date the Qualified Beneficiary is notified of the right to elect continuation coverage.

If the Qualified Beneficiary does not elect continuation coverage, coverage under the group health plan available under the Plan shall cease. If the Qualified Beneficiary chooses continuation coverage, such group health plan shall provide coverage identical to that available to similarly situated active employees, including the opportunity to choose among options available during an open enrollment period.

(e) Cost. The Qualified Beneficiary must pay the full cost of such coverage to the Plan for a similarly situated active employee. The Plan may charge a 2% administrative fee. The COBRA premium may increase to 150% of the total premium during a disability extension as described in paragraph (f)(iv).

(f) Maximum Continuation Period.

(i) A Qualified Beneficiary who loses group health plan coverage available under the Plan as a result of the death of the Participant, the Participant's eligibility for Medicare, divorce, legal separation or loss of Dependent status under such group health plan and elects COBRA continuation coverage shall be entitled to receive up to 36 months of COBRA continuation coverage beginning on the date on which the qualifying event occurred.

(ii) A Qualified Beneficiary who loses group health plan coverage as a result of the Participant's termination of employment or reduction of hours and elects COBRA continuation coverage shall be entitled to receive up to 18 months of COBRA continuation coverage beginning on the date on which the qualifying event occurred. If a second qualifying event occurs during such 18-month period, the COBRA continuation coverage period may be extended by an additional 18 months for each Qualified Beneficiary (other than a covered Employee). The Qualified Beneficiary must notify the Plan Administrator within 60 days of a second qualifying event to receive the additional 18 months of continuation coverage. A second qualifying event is an event that occurs during the initial 18-month period that would have resulted in a loss of group health plan coverage for the Qualified Beneficiary in the absence of
the first qualifying event. In no event, however, shall any Qualified Beneficiary's COBRA continuation coverage period exceed 36 months.

(iii) A Qualified Beneficiary (other than the Participant) who loses group health plan coverage as a result of the Participant’s termination of employment or reduction of hours and such event occurs within 18 months following the Participant’s enrollment in Medicare, shall be entitled to receive up to 36 months of COBRA continuation coverage beginning on the date the Participant enrolled in Medicare.

(iv) If a qualifying event occurs that is the Participant's termination of employment or reduction of hours, any Qualified Beneficiary who is deemed to have been disabled, as determined by the Social Security Administration, at any time during the first 60 days of COBRA continuation coverage shall be eligible to extend the COBRA continuation coverage period to 29 months. In the case of a child born to or adopted by a Participant during the Participant's COBRA continuation coverage period, such 60-day period will begin from the date of birth or placement of adoption. Such extension shall apply to the Qualified Beneficiary's covered family members. Such Qualified Beneficiary must notify the Plan Administrator of the disability in writing within 60 days of the date of the Social Security Administration determination and before the end of the 18-month continuation coverage period. A Qualified Beneficiary receiving extended COBRA continuation coverage due to disability must inform the Plan Administrator within 30 days of receiving a final determination that he or she is no longer disabled.

(v) In the case of a qualifying event that is the bankruptcy of the Employer, the maximum coverage period for a Qualified Beneficiary who is the retired covered employee ends on the date of the retired covered employee's death. The maximum coverage period for a Qualified Beneficiary who is the spouse, surviving spouse, or dependent child of the retired covered employee ends on the earlier of—(A) The date of the Qualified Beneficiary's death; or (B) The date that is 36 months after the death of the retired covered employee.

(g) Termination of COBRA Continuation Coverage. COBRA continuation coverage shall cease upon the occurrence of any of the following events:

(i) The Employer ceases to provide group health plan coverage to any of its employees;

(ii) The Qualified Beneficiary fails to pay the premium or required contribution within 30 days after its due date;

(iii) The Qualified Beneficiary becomes covered, after the date of the COBRA continuation coverage election, under another group health plan, including a governmental plan, that does not contain any exclusion or limitation with respect to any preexisting condition of such Qualified Beneficiary (other than an exclusion or limitation that may be disregarded under the law);
(iv) The Qualified Beneficiary becomes enrolled in Medicare after the
date of the COBRA continuation coverage election;

(v) The Qualified Beneficiary has extended COBRA continuation
coverage due to a disability and is subsequently determined by the Social Security
Administration to be no longer disabled;

(vi) The maximum required COBRA continuation coverage period
expires; or

(vii) For cause, such as fraudulent claim submission, that would result
in termination of coverage for a similarly situated active employee.

(h) Second Election Period. A Participant and his or her covered family
members may be eligible to elect continuation coverage during a second election period if such
Participant:

(i) is receiving trade adjustment assistance benefits under the Trade
Act of 2002 (or would be eligible to receive trade adjustment assistance benefits but has not
exhausted unemployment benefits);

(ii) lost health coverage due to termination of employment that
resulted in eligibility for trade adjustment assistance benefits under the Trade Act of 2002; and

(iii) did not elect COBRA continuation coverage during the initial
COBRA election period.

The second election period is the 60-day period beginning on the first day of the
month in which the Participant becomes eligible for such second election period, but only if the
election is within the six-month period after the Participant initially lost coverage. COBRA
continuation coverage begins on the first day of the second election period. Such coverage is not
retroactive to the date the Participant initially lost coverage.

7.10 Genetic Information Nondiscrimination Act of 2008 (“GINA”). (a) Unless
otherwise permitted, the Employer may not request or require any genetic information from an
Employee or family member of the Employee.

(b) “Genetic information” as defined by GINA includes an individual’s family
medical history, the results of an individual’s or family member’s genetic tests, the fact that an
individual or an individual’s family member sought or received genetic services, and genetic
information of a fetus carried by an individual or an individual’s family member or an embryo
lawfully held by an individual or family member receiving assistive reproductive services.

(c) The Employer shall not request any genetic information when requesting
health-related information. However, with respect to any wellness program available under the
Plan, the Employer may request, but may not require, an Employee to provide genetic information in accordance with Equal Employment Opportunity Commission regulations.

(d) The Employer will not request, require or purchase genetic information in violation of GINA. If the Employer intentionally or unintentionally obtains genetic information pertaining to an Employee or a family member of the Employee, the Employer will not use such genetic information in violation of GINA. Any genetic information received by the Employer that pertains to an Employee or a family member of the Employee, shall be maintained on forms and in medical files that are separate from personnel files, and shall be treated as confidential medical records.

7.11 Health-Related Factors. The group health plan will not discriminate against any participant or dependent in terms of eligibility to participate in the plan based on a health-related factor. In addition, benefits provided under the group health plan will be available to all similarly situated individuals. Any restriction on benefits will be applied uniformly to all similarly situated individuals and may not be directed at an individual based on a health-related factor. The group health plan may (i) limit or exclude benefits that are experimental or are not medically necessary and (ii) require an individual to satisfy a deductible, copay, coinsurance, or other cost-sharing requirement in order to obtain a benefit, provided that all limits, exclusions, or cost-sharing requirements apply uniformly to all similarly situated individuals, and are not just directed at an individual based on a health-related factor.

7.12 Mental Health Parity Act. The group health plan must generally comply with the provisions of the Mental Health Parity and Addiction Equity Act of 2008, including that the group health plan’s financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) that are applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

ARTICLE VIII
Amendment and Termination

8.1 Amendment. The Employer has the right to amend the Plan at any time, including the right to amend any of the Welfare Programs or to transfer any Welfare Program from the Plan into a separate, related plan, at the direction of an authorized officer of the Employer or an authorized designee.

8.2 Termination. The Employer has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but the Employer is not and shall not be under any obligation or liability whatsoever to maintain the Plan (or any Welfare Program) for any given length of time and may, in its sole and absolute discretion, discontinue or terminate the Plan, in whole or in part, at any time, including termination of any one or more of the Welfare Programs, at the direction of an authorized officer of the Employer or an authorized designee.
ARTICLE IX

Miscellaneous

9.1 Exclusive Benefit. This Plan has been established for the exclusive benefit of Participants, Spouses, Dependents or Beneficiaries, and except as otherwise provided herein, all contributions under the Plan may be used only for such purpose.

9.2 Non-Alienation of Benefits. No benefit, right or interest of any Participant, Spouse, Dependent or Beneficiary under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process, or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law or, in the case of assignments, as permitted under the terms of a Welfare Program.

9.3 Limitation of Rights. Neither the establishment nor the existence of the Plan, nor any modification thereof, shall operate or be construed as to:

(a) give any person any legal or equitable right against the Employer (or Participating Employer) except as expressly provided herein or required by law, or

(b) create a contract of employment with any Employee, obligate the Employer (or Participating Employer) to continue the service of any Employee, or affect or modify the terms of an Employee’s employment in any way.

9.4 Governing Laws and Jurisdiction and Venue. The Plan shall be construed and enforced according to the laws of the state of Rhode Island to the extent not preempted by federal law which shall otherwise control. Exclusive jurisdiction and venue of all disputes arising out of or relating to this Plan or any of the Welfare Programs shall be in any court of appropriate jurisdiction in the state of Rhode Island.

9.5 Severability. If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such invalid or unenforceable provision had not been included herein.

9.6 Construction. The captions contained herein are inserted only as a matter of convenience and reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof. Any terms expressed in the singular form shall be construed as though they also include the plural, where applicable, and references to the masculine, feminine, and the neuter are interchangeable.

9.7 Titles. The titles of the Articles and Sections hereof are included for convenience only and shall not be construed as part of the Plan or in any respect affecting or modifying its
provisions. Such words in this Plan as “herein,” “hereinafter,” “hereof” and “hereunder” refer to this instrument as a whole and not merely to the subdivision in which said words appear.

9.8 Expenses. Subject to the terms of the Welfare Programs, any expenses incurred in the administration of the Plan shall be paid by the Plan and/or by the Employer, according to the Employer’s determination.

ARTICLE X

Participating Employers

10.1 Adoption of the Plan. This Plan may be adopted by a Participating Employer, provided that such adoption is with the approval of the Employer. Such adoption shall be by resolution of the Participating Employer’s governing body.

10.2 Administration. As a condition to adopting the Plan, and except as otherwise provided herein, each Participating Employer shall be deemed to have authorized the Plan Administrator to act for it in all matters arising under or with respect to the Plan and shall comply with such other terms and conditions as may be imposed by the Plan Administrator.

10.3 Termination of Participation. Each Participating Employer may cease to participate in the Plan or in any Welfare Program with respect to its Employees or former Employees by resolution of its governing body.

ARTICLE XI

Effective Date

The effective date of this Plan is January 01, 2021.

* * * * *
IN WITNESS WHEREOF, the Employer has caused this instrument to be duly executed in its name and on its behalf as of the date set forth below.

Children's Friend and Service

By: ______________________________
Date: ______________________________

ATTEST:

_________________________________
The following Welfare Programs shall be treated as part of the Plan pursuant to Section 2.15 and as defined in Section 2.19:

**Welfare Programs**

**ASO Navigate GIL Mod $0**
Carrier’s or Program Administrator’s Name: Children's Friend and Service
Address: 153 Summer Street
Providence, Rhode Island 02903
(401) 276-4300
- Such other contracts as may, from time to time, replace any or all of the contracts listed above

**Delta Dental PPO Plus Premier**
Carrier’s or Program Administrator’s Name: Delta Dental Of RI
Contract Number: 4160-0001
Address: PO Box 1517
Providence, Rhode Island 02901
(401) 752-6000
https://www.deltadentalri.com
- Such other contracts as may, from time to time, replace any or all of the contracts listed above

**Life Insurance Plan**
Carrier’s or Program Administrator’s Name: UNUM
Contract Number: 395970
Address: 125 Summer St, Suite 2000
Boston, Massachusetts 02110
(800) 632-1188
http://www.unum.com
- Such other contracts as may, from time to time, replace any or all of the contracts listed above

**Long-Term Disability Plan**
Carrier’s or Program Administrator’s Name: UNUM
Contract Number: 395970
Address: 125 Summer St, Suite 2000
Boston, Massachusetts 02110
(800) 632-1188
http://www.unum.com
- Such other contracts as may, from time to time, replace any or all of the contracts listed above

**ASO Navigate GIL Mod $750**
Carrier’s or Program Administrator’s Name: Children's Friend and Service
Address: 153 Summer Street
        Providence, Rhode Island 02903
        (401) 276-4300

• Such other contracts as may, from time to time, replace any or all of the contracts listed above

Dependent Care Reimbursement Account (DCRA) Plan
Carrier’s or Program Administrator’s Name: Health Equity
Address: 15 W. Scenic Pointe Drive, Ste. 100
        Draper, Utah 84020
        (866) 382-3510
        http://www.healthequity.com

• Such other contracts as may, from time to time, replace any or all of the contracts listed above

Health Care Flexible Spending Account
Carrier’s or Program Administrator’s Name: Health Equity
Address: 15 W. Scenic Pointe Drive, Ste. 100
        Draper, Utah 84020
        (866) 382-3510
        http://www.healthequity.com

• Such other contracts as may, from time to time, replace any or all of the contracts listed above

UnitedHealthcare Vision
Carrier’s or Program Administrator’s Name: United Healthcare New England
Contract Number: 753421
Address: 475 Kilvert Street
        Warwick, Rhode Island 02886
        (888) 735-5842

• Such other contracts as may, from time to time, replace any or all of the contracts listed above

Premium Conversion Plan
Carrier’s or Program Administrator’s Name: Children's Friend and Service
Address: 153 Summer Street
        Providence, Rhode Island 02903
        (401) 276-4300

• Such other contracts as may, from time to time, replace any or all of the contracts listed above
APPENDIX B
CHILDREN'S FRIEND & SERVICE

PARTICIPATING EMPLOYERS

In addition to Children's Friend and Service, the following Participating Employers have adopted the Plan pursuant to Section 10.1:

There are no other employers participating in the Plan.
Spanish:
Este folleto contiene un resumen en inglés de los derechos y beneficios de su plan bajo su Programa de Beneficio Social. Si encuentra alguna dificultad para entender cualquier parte de este folleto, póngase en contacto con su Administrador(a) del Plan. Para mayor información, por favor póngase en contacto con: (401) 276-4300
**CHILDREN'S FRIEND & SERVICE**

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CHILDREN'S FRIEND & SERVICE

WRAP SUMMARY PLAN DESCRIPTION

This document, along with the benefits booklets and certificates, and provider contracts, policies and descriptions, is the summary plan description (“SPD”) for the Children's Friend & Service (the “Plan”). These documents describe the Plan as in effect on January 01, 2021. The Plan may be changed from time to time.

Because the benefits you receive through the Plan will be of importance to you and your family, you should retain this SPD as part of your permanent records. However, remember that it is only a summary. The SPD summarizes who is eligible for benefits and the nature of the benefits available. The SPD does not change the provisions of any benefit plan documents or any legal instrument related to the creation, operation, funding, or benefit payment obligations of the benefit plans.

For additional information regarding the Plan, you should contact the Benefits & Wellness Specialist at (401) 276-4300 or refer to the Welfare Program documents and the full insurance contracts. Copies of the documents are available from the Employer on request. If the terms of this SPD conflict with the Plan documents, the Plan documents shall govern.

GENERAL PLAN INFORMATION

Type of Plan: Welfare, including the following Welfare Programs: ASO Navigate GIL Mod $0, Delta Dental PPO Plus Premier, Life Insurance Plan, Long-Term Disability Plan, ASO Navigate GIL Mod $750, Dependent Care Reimbursement Account (DCRA) Plan, Health Care Flexible Spending Account, UnitedHealthcare Vision, Premium Conversion Plan as enumerated in Appendix A

Plan Name: Children's Friend & Service (the “Plan”)

Plan Number: 501

Plan Year: The Plan Year is the twelve month period ending December 31.

Plan Sponsor: Children's Friend and Service (the “Employer”)
153 Summer Street
Providence, Rhode Island 02903
(401) 276-4300
For a list of Participating Employers, please refer to Appendix B.

Plan Sponsor’s Employer Identification Number: 05-0258819
Plan Administrator: Children's Friend and Service  
153 Summer Street  
Providence, Rhode Island 02903  
(401) 276-4300

Agent for Service of Legal Process: Children's Friend and Service  
153 Summer Street  
Providence, Rhode Island 02903  
(401) 276-4300

Service of legal process may also be made upon the Plan Administrator.

Plan Administration: Welfare Programs available under the Plan are administered by providers/insurers from which services or benefits are purchased. Unless otherwise indicated, all benefit plans are administered by the respective insurers or providers who provide and guarantee the benefits. Self-insured or unfunded benefits, if any, are paid from the Employer’s general assets.

Claims Administrators: See chart below and/or the separate summary that may apply to a particular type of coverage.

<table>
<thead>
<tr>
<th>For Claims On</th>
<th>Claims Administrator Name</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASO Navigate GIL Mod $0</td>
<td>Children's Friend and Service</td>
<td>(401) 276-4300</td>
</tr>
<tr>
<td>Delta Dental PPO Plus Premier</td>
<td>Delta Dental Of RI</td>
<td>(401) 752-6000</td>
</tr>
<tr>
<td>Life Insurance Plan</td>
<td>UNUM</td>
<td>(800) 632-1188</td>
</tr>
<tr>
<td>Long-Term Disability Plan</td>
<td>UNUM</td>
<td>(800) 632-1188</td>
</tr>
<tr>
<td>ASO Navigate GIL Mod $750</td>
<td>Children's Friend and Service</td>
<td>(401) 276-4300</td>
</tr>
<tr>
<td>Dependent Care Reimbursement Account (DCRA) Plan</td>
<td>Health Equity</td>
<td>(866) 382-3510</td>
</tr>
<tr>
<td>Health Care Flexible Spending Account</td>
<td>Health Equity</td>
<td>(866) 382-3510</td>
</tr>
<tr>
<td>UnitedHealthcare Vision</td>
<td>United Healthcare New England</td>
<td>(888) 735-5842</td>
</tr>
<tr>
<td>Premium Conversion Plan</td>
<td>Children's Friend and Service</td>
<td>(401) 276-4300</td>
</tr>
</tbody>
</table>
ELIGIBILITY AND BENEFITS

An Employee (and his or her Spouse and Dependents, if applicable) is eligible to participate in the Plan only if and to the extent the Participant is eligible with respect to a particular type of coverage under the Plan and the Participant makes the required employee contribution for the coverage selected. The Plan Administrator will inform you of the amount of required employee contributions, if any, for each type of coverage.

In general, the eligibility requirements for each type of coverage include the following:

<table>
<thead>
<tr>
<th>ASO Navigate GIL Mod $0</th>
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<td>(401) 276-4300</td>
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</table>

| Funding Medium | Self-Insured – The benefit is self-insured |

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<thead>
<tr>
<th>Eligibility</th>
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<td>Spouse</td>
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<td></td>
<td>Dependent/Child</td>
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<td>Domestic Partner</td>
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</table>

| Employees Excluded from Coverage | Not Applicable |

| Waiting Period | An Employee is eligible to participate first of the month following date of hire. |

| Effective Date of Coverage | Plan coverage begins on the first day of the calendar month after the end of the Waiting Period. |

| Coverage Termination | Plan coverage will terminate at the end of the month in which the Employee terminates employment or is no longer an eligible Employee under the Plan’s provisions. |

<table>
<thead>
<tr>
<th>Delta Dental PPO Plus Premier</th>
<th>Delta Dental Of RI</th>
</tr>
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<tbody>
<tr>
<td>Provider or Program Administrator Information</td>
<td>4160-0001 (Contract Number)</td>
</tr>
<tr>
<td></td>
<td>PO Box 1517</td>
</tr>
<tr>
<td></td>
<td>Providence, Rhode Island 02901</td>
</tr>
<tr>
<td></td>
<td>(401) 752-6000</td>
</tr>
<tr>
<td></td>
<td><a href="https://www.deltadentalri.com">https://www.deltadentalri.com</a></td>
</tr>
</tbody>
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| Funding Medium | Fully Insured – The benefit is fully insured by the above named Provider |

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<td>Dependent/Child Domestic Partner</td>
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**Life Insurance Plan**

<table>
<thead>
<tr>
<th>Provider or Program Administrator Information</th>
<th>UNUM 395970 (Contract Number) 125 Summer St, Suite 2000 Boston, Massachusetts 02110 (800) 632-1188 <a href="http://www.unum.com">http://www.unum.com</a></th>
</tr>
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<tbody>
<tr>
<td>Funding Medium</td>
<td>Fully Insured – The benefit is fully insured by the above named Provider</td>
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<td>Eligibility</td>
<td>Generally, employees who work an average of 30 hour(s) per week. Spouse Dependent/Child Domestic Partner</td>
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**Long-Term Disability Plan**

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<th>named Provider</th>
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### Eligibility
Generally, employees who work an average of 30 hour(s) per week.
- Spouse
- Dependent/Child
- Domestic Partner

### Employees Excluded from Coverage
Not Applicable

### Waiting Period
An Employee is eligible to participate first of the month following date of hire.

### Effective Date of Coverage
Plan coverage begins on the first day of the calendar month after the end of the Waiting Period.

### Coverage Termination
Plan coverage will terminate at the end of the month in which the Employee terminates employment or is no longer an eligible Employee under the Plan’s provisions.

### ASO Navigate GIL Mod $750

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### Dependent Care Reimbursement Account (DCRA) Plan

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<thead>
<tr>
<th>Provider or Program Administrator Information</th>
<th>Health Equity</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>15 W. Scenic Pointe Drive, Ste. 100</td>
</tr>
<tr>
<td></td>
<td>Draper, Utah 84020</td>
</tr>
<tr>
<td></td>
<td>(866) 382-3510</td>
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<td></td>
<td><a href="http://www.healthequity.com">http://www.healthequity.com</a></td>
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<td>Coverage Termination</td>
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</table>

**Health Care Flexible Spending Account**

| Provider or Program Administrator Information   | Health Equity  
15 W. Scenic Pointe Drive, Ste. 100  
Draper, Utah 84020  
(866) 382-3510  
http://www.healthequity.com |
<table>
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**UnitedHealthcare Vision**

| Provider or Program Administrator Information   | United Healthcare New England  
753421 (Contract Number)  
475 Kilvert Street |
|-------------------------------------------------|---------------------------------------------------------------------------------------------------------|
To the extent required by applicable law under the Patient Protection and Affordable Care Act ("ACA"), for certain companies with 50 or more full-time Employees, the number of hours worked to obtain full-time status for group health plan coverage purposes will be determined in accordance with certain measurement rules adopted by the Employer for all Employees (including variable hour and seasonal employees, if such classes exist within the Employer). A temporary Employee is not eligible for coverage if he or she is eligible for health coverage through a leasing company, unless otherwise required by the ACA and the Employer. Determination of full-time Employee status will be made by the Plan Administrator, in its sole and absolute discretion, in accordance with the Plan and the applicable Employer Shared Responsibility provisions of the ACA and its accompanying regulations. This eligibility information is available upon request to the Plan Administrator.

Under ERISA, the Plan Administrator of the group health plan may have fiduciary responsibilities regarding distribution of dividends, demutualization and use of the Medical Loss Ratio rebates from group health insurers. Some or all of any rebate may be an asset of the plan, which must be used for the benefit of the participants covered by the policy. Participants should contact the Plan Administrator directly for information on how the rebate will be used.

ENROLLING IN THE PLAN

The Plan Administrator will establish procedures in accordance with each type of coverage for the enrollment of eligible Employees, their Spouses or Dependents, if any, and will communicate these procedures to eligible Employees. The Plan Administrator will prescribe enrollment forms that must be completed by a prescribed deadline prior to commencement of coverage under the Plan.
DISCRIMINATION BASED ON HEALTH-RELATED FACTORS PROHIBITED

A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") prohibits health plans from discriminating against any participant or dependent in terms of eligibility to participate in the Plan based on a health-related factor. Accordingly, benefits provided under your Plan will be available to all similarly situated individuals. Any restriction on benefits will be applied uniformly to all similarly situated individuals and may not be directed at an individual based on a health-related factor. The Plan may (i) limit or exclude benefits that are experimental or are not medically necessary and (ii) require an individual to satisfy a deductible, copay, coinsurance, or other cost-sharing requirement in order to obtain a benefit, provided that all limits, exclusions, or cost-sharing requirements apply uniformly to all similarly situated individuals, and are not just directed at an individual based on a health-related factor.

HIPAA PRIVACY ISSUES

HIPAA also requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan’s Privacy Notice or, if appropriate, in the privacy notice provided by the insurer. To obtain a copy of the privacy notice, contact the insurer or, if you have questions or complaints about the privacy of your health information, contact the Plan Administrator.

Neither this Plan nor the Employer will use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA’s privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan, your insurer, or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself, your Spouse or Dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Spouse and Dependents in this plan if you or your Spouse or Dependents lose eligibility for that other coverage (or if the Employer stops contributing towards your or your Spouse's or Dependents' other coverage). However, you must request enrollment within 30 days after your or your Spouse's or Dependents' other coverage ends (or after the Employer stops contributing toward the other coverage).

In addition, if you have a new Spouse or Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Spouse and Dependents. However,
you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your Spouse or Dependents are eligible, but not enrolled, in the Group Medical Plan listed in Appendix A you may enroll when:

- Medicaid or Children’s Health Insurance Program (“CHIP”) coverage is terminated as a result of loss of eligibility and you request coverage under the Group Medical Plan listed in Appendix A within 60 days after the termination, or
- You or your Spouse or Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP and you request coverage under the Group Medical Plan listed in Appendix A within 60 days after eligibility is determined.

The special enrollment rules do not apply to limited scope dental or vision benefits or certain health care flexible spending accounts (e.g., spending accounts that limit benefits to employee salary reduction amounts).

To request special enrollment or obtain more information, contact the Plan Administrator.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

A qualified medical child support order (“QMCSO”) is an order made pursuant to state domestic relations law by a court or a state agency authorized under state law to issue child support orders which requires a group health plan to provide coverage to a child or children of an Employee. The Plan Administrator shall comply with the terms of any QMCSO it receives, and shall:

(a) Establish reasonable procedures to determine whether a medical child support order is a QMCSO (these procedures are available, free of charge, to Participants and Beneficiaries upon request to the Plan Administrator);

(b) Promptly notify the Employee and the child (or child’s guardian) of the receipt of any medical child support order, and the group medical plan’s procedures for determining whether a medical child support order is a QMCSO; and

(c) Within a reasonable period of time after receipt of such order, determine whether such order is a QMCSO and notify the Employee and the child of such determination.

STATE MEDICAID PROGRAMS

Eligibility for coverage or enrollment in a State Medicaid Program will not impact your eligibility or a Spouse’s or Dependent’s in this Plan. Payment of benefits shall be in accordance with any assignment of rights as required by any State Medicaid Program.

If a Welfare Program available under this Plan contains provisions regarding coordination of benefits with State Medicaid Programs, the language in the written materials for such Welfare Program will govern unless the language fails to comply with applicable laws and regulations.
SPECIAL RULES FOR MATERNITY AND INFANT COVERAGE

Group health plans and health insurance issuers generally may not, under federal law, 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 cesarean section. However, federal law generally does not prohibit the attending provider or physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing the length of stay not in excess of 48 hours or 96 hours, as the case may be.

SPECIAL RULE FOR WOMEN’S HEALTH COVERAGE

The Women’s Health and Cancer Rights Act of 1998 requires group health plans, insurance issuers and HMOs who already provide medical and surgical benefits for mastectomy procedures to provide insurance coverage for reconstructive surgery following mastectomies. This expanded coverage includes (i) reconstruction of the breast on which the mastectomy has been performed, (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (iii) prostheses and treatment of physical complications at all stages of mastectomy, including lymphedema. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other benefits under the plan or coverage. For answers to specific questions regarding your particular health plan’s policy, contact the Plan Administrator.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008

The Genetic Information Nondiscrimination Act of 2008 (“GINA”) protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

MENTAL HEALTH PARITY

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

HEALTH COVERAGE DURING UNPAID FMLA LEAVE

If your Employer has at least 50 employees employed within 75 miles of your worksite and you take an approved unpaid leave of absence that qualifies as family and medical leave under the Family and Medical Leave Act of 1993 (FMLA), you may generally continue to receive group health coverage for yourself and your covered Spouse and Dependents. Coverage will terminate at the end of your FMLA leave period if you do not return from leave, or on the date you give notice that you will not be returning from FMLA leave, and you may then be eligible for COBRA continuation coverage (as
described below). To receive group health plan coverage during unpaid FMLA leave, you must continue to pay your share of the premium. You should contact the Plan Administrator to make arrangements for premium payments during unpaid FMLA leave. If you do not continue your group health plan coverage or other types of coverage during unpaid FMLA leave, your coverages will be reinstated when you return from FMLA leave. For additional information about Plan coverage during FMLA leave, contact the Plan Administrator.

Additional family and medical leave or sick leave rights may apply under state law. Please contact the Plan Administrator for further information.

WELLNESS PLAN

Your Employer is committed to helping you achieve your best health. Therefore, we have instituted a wellness plan to improve and promote your health and fitness. The completion of some of the programs in the wellness plan may result in rewards, such as a reduction in health plan contribution costs for you and, if participating in the wellness program, for your spouse.

If you think you might be unable to meet a standard for a reward under a particular wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the Plan Administrator at (401) 276-4300 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you.

For further information regarding the wellness plan, please contact the Plan Administrator or refer to your benefit plan component documents.

UNIFORMED SERVICES REEMPLOYMENT RIGHTS

Your right to continued participation in a group health plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (“USERRA”). Accordingly, if you are absent from work due to a period of active duty in the military you may elect to continue your group health plan coverage. If you are absent for less than 31 days, you will pay the regular employee share of the cost of the health coverage. If the absence is for 31 or more days, the cost of continuation coverage may not exceed 102% of the full cost of your health coverage.

Continuation coverage will terminate on the earlier of:

- The last day of the 24 month period beginning on the first day of military leave, or
- The date you fail to apply for reemployment, as required under USERRA, after returning from military leave.

USERRA continuation coverage is considered alternative coverage for purposes of COBRA. Therefore, if you elect USERRA continuation coverage, COBRA coverage will generally not be available.

Benefits during a period of military leave must be as generous as benefits available to similarly situated employees on other employer-approved leaves of absence (e.g., family and medical leave).
COBRA CONTINUATION COVERAGE

Under a federal law called COBRA ("Consolidated Omnibus Budget Reconciliation Act"), group health plans of most employers with 20 or more employees are generally required to offer covered Employees, their covered Spouses and Dependents the opportunity to make separate elections to extend group health coverage temporarily at group rates after coverage under the Plan would otherwise cease. This extension is called COBRA continuation coverage. Evidence of your good health is not required for this extension. Domestic partners should contact the Plan Administrator to discuss eligibility for continuation coverage.

As an Employee covered under the Plan, you may have the right to elect COBRA continuation coverage if you lose health coverage (or premium payments or contributions for health coverage increase) because:

- Your hours of employment are reduced;
- Your employment is terminated for reasons other than gross misconduct; or
- The Employer starts bankruptcy proceedings under Title XI, if you are a retired employee.

Your Spouse may elect continuation health coverage if he or she loses health coverage (or premium payments or contributions for health coverage increase) under the Plan because:

- Your employment is terminated for reasons other than gross misconduct, or your hours of employment are reduced;
- You die;
- You divorce or become legally separated;
- You become enrolled in Medicare (Part A or B); or
- The Employer starts bankruptcy proceedings under Title XI, and you are retired.

Your dependent child may continue health coverage if he or she loses health coverage (or premium payments or contributions for health coverage increase) under the Plan because:

- He or she loses Dependent status under the Plan;
- Your employment is terminated for reasons other than gross misconduct, or your hours of employment are reduced;
- You die;
- You and your Spouse divorce or become legally separated;
- You become enrolled in Medicare (Part A or B); or
- The Employer starts bankruptcy proceedings under Title XI, and you are retired.

A child born to, adopted by, or placed for adoption with the covered Employee during the continuation coverage period may also be entitled to elect COBRA continuation coverage. Such child’s coverage period will be determined according to the date of the qualifying event that gave rise to the covered Employee’s COBRA coverage. You must notify the Plan Administrator within 30 days and provide supporting documentation.
Under COBRA, you (or your Spouse or dependent child, if applicable) must notify the Plan Administrator by filing a Change of Status notice with the Plan Administrator within 60 days after:

- You and your Spouse are divorced or legally separated; or
- One of your children loses Dependent status under the Plan.

You (or your Spouse or dependent child, if applicable) will then be notified of the right to elect continuation health coverage and the cost to do so. The deadline for electing continuation health coverage is 60 days after the date the Plan ceases to cover you or your Spouse or dependent child, or 60 days from the date you, your Spouse, or dependent child are notified of your COBRA election rights, whichever is later.

If you (or your Spouse or dependent children, if applicable) do not elect continuation coverage, your health coverage will stop. If you (or your Spouse or dependent children, if applicable) choose continuation health coverage, the Plan will provide health coverage identical to that available to similarly situated active employees, including the opportunity to choose among options available during an open enrollment period. However, you (or your Spouse or dependent child, if applicable) must pay for this coverage. The COBRA premium will not exceed 102% of the total premium paid by you and your Employer for that level of coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium.

If the original qualifying event causing the loss of health coverage was the death of the Employee, divorce, legal separation, Medicare entitlement, or loss of “dependent status” of a dependent child under the Plan, then each qualified beneficiary will have the opportunity to elect 36 months of continuation coverage from the date of the qualifying event. If you (or your Spouse or dependent child, if applicable) lose health coverage under the Plan because your employment was terminated or your hours of employment were reduced (and not immediately followed by termination of employment), then the maximum continuation period will be 18 months from the date of the qualifying event. (If coverage is lost at a date later than the date of the qualifying event and the Plan measures the maximum coverage period and notice period from the date of health coverage loss, then the maximum continuation period will be 18 months from the date of health coverage loss.) If during those 18 months, another qualifying event takes place that entitles your Spouse (or dependent child, if applicable) to continuation health coverage, your Spouse’s continuation coverage (or dependent child’s continuation coverage, if applicable) may be extended by another 18 months. You must make sure that the Plan Administrator/COBRA Administrator is notified of the second qualifying event within 60 days of the second qualifying event. In no event will your Spouse’s health continuation coverage (or your dependent child’s health continuation coverage, if applicable) extend for more than a total of 36 months from the date of the initial event. If your covered Spouse and/or dependent child lose coverage due to your termination of employment (for reasons other than gross misconduct) or reduction in hours and such loss occurs within 18 months after you enroll in Medicare, then the maximum continuation coverage period for your Spouse and dependent child shall be 36 months from the date you enrolled in Medicare.

Disability is a special issue. If the Social Security Administration determines that you (or your Spouse or dependent child, if applicable) are disabled at any time during the first 60 days of the
continuation health coverage period, or in the case of a child born to, adopted by or placed for adoption with a covered Employee during a COBRA coverage period, during the first 60 days after a child’s birth, adoption or placement for adoption, then your continuation coverage period as well as your Spouse’s and any Dependent’s continuation periods may be extended from 18 months to 29 months. The Employer may charge up to 150% of the total premium paid by you and the Employer during this extended period. To qualify, you (or your Spouse or dependent child, if applicable) must notify the Plan Administrator in writing within 60 days of the date of the Social Security Administration determination and during the initial 18 month continuation coverage period. Your written notice must include your name, Social Security Number, and indicate you have continuation coverage under the Plan. If there is a final determination that the qualified beneficiary is no longer disabled, the Plan Administrator must be notified within 30 days of the determination by the qualified beneficiary, and any health coverage extended beyond the maximum that would otherwise apply will be terminated for all qualified beneficiaries.

In certain circumstances, bankruptcy under Title XI of the Employer will entitle you to continuation health coverage. If the qualifying event causing the loss of health coverage was the bankruptcy of the Employer under Title XI, then each covered retired employee will have the opportunity to receive continuation health coverage until the death of the covered retired employee. Covered spouses, surviving spouses and dependents of the covered retired employee will have the opportunity to elect continuation health coverage for a period that will terminate 36 months following the death of the retired employee or upon the death of the qualified beneficiary, whichever is earlier.

Your right to continuation health coverage (or your Spouse’s or dependent child’s right, if applicable) under COBRA ends if:

- The Employer ceases to provide group health coverage to any of its employees;
- You (or your Spouse or dependent child, if applicable) fail to pay the premium within 30 days after its monthly due date;
- You (or your Spouse or dependent child, if applicable) become covered, after the date of your COBRA election, under another group health plan, including a governmental plan, that does not contain any exclusion or limitation with respect to any preexisting condition of such qualified beneficiary (other than an exclusion or limitation that may be disregarded under the law);
- You (or your Spouse or dependent child, if applicable) become entitled to Medicare after the date of the COBRA election;
- You (or your Spouse or dependent child, if applicable) have extended continuation coverage due to a disability and then you are determined by the Social Security Administration to be no longer disabled;
- The maximum required COBRA continuation period expires; or
- For such cause, such as fraudulent claim submission, that would result in termination of coverage for similarly situated active employees.

In order to protect your family’s rights, you should keep the Plan Administrator/COBRA Administrator informed of any changes in the addresses of your family members. You should also keep a copy of any notices you send the Plan or COBRA Administrator.
Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Additional continuation rights may apply under state law. Please contact the Plan Administrator for further information.

CLAIMS PROCEDURES FOR THE PLAN

Except as provided below, claims for benefits under each Plan that is either insured or self-insured will be reviewed in accordance with procedures contained in the policies, contracts, summary plan descriptions or other written materials for such Plan benefits. All other general claims or requests should be directed to the Claims Administrator. If a claim under the Plan is denied in whole or in part, the Claims Administrator will notify you or your beneficiary in writing of such denial within 90 days of receipt of the claim. (This period may be extended to 180 days under certain circumstances.) The notification will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. Within 60 days after receipt of a notice of denial, you or your beneficiary may submit a written request for reconsideration of the application to the Claims Administrator.

Any such request should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing. The Claims Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended to 120 days under certain circumstances.) In this response, the Claims Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Claims Administrator has the exclusive right to interpret the provisions of the Plan. Decisions of the Claims Administrator are final, conclusive and binding.

CLAIMS PROCEDURE FOR BENEFITS BASED ON DETERMINATION OF DISABILITY

The following claims procedure shall apply specifically to claims made under the Plan for benefits based on a determination of disability. To the extent that this procedure is inconsistent with the claims procedure contained in the policies, contracts, summary plan descriptions or other written materials for such plans, the claims procedure in the other policies, contracts, summary plan descriptions, or other written materials shall supersede this procedure as long as such other claims procedure complies with Department of Labor Regulations.

If a claim under the Plan for a benefit based on a determination of disability is denied in whole or in part, you or your beneficiary will receive written notification regarding the claim denial. This claim denial will include the reasons for the denial, reference to the Plan provision supporting the denial, and a description of the Plan’s appeals procedures. The discussion of the claim denial will also include:
• if applicable, an explanation for disagreeing with or not following the views of health care professionals or vocational experts, or with a disability benefit determination made by the Social Security Administration;

• the internal rules, guidelines, protocols, standards, or other similar criteria of the Plan that were relied upon in denying the claim (or a statement that such rules, guidelines, protocols, standards, or other similar criteria do not exist); and

• a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits; and, if applicable, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant’s medical circumstances (or a statement that such explanation will be provided free of charge upon request).

You will receive a benefit denial notice within a reasonable period of time, but no later than 45 days after the Claims Administrator’s receipt of the claim. The Claims Administrator may extend this period for up to 30 additional days provided the Claims Administrator determines that the extension is necessary due to matters beyond the Claims Administrator’s control and the claimant is notified of the extension before the end of the initial 45-day period and is also notified of the date by which the Claims Administrator expects to render a decision. The 30-day extension can be extended by an additional 30 days if the Claims Administrator determines that, due to matters beyond its control, it cannot make the decision within the original extended period. In that event, you will be notified before the end of the initial 30-day extension of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

The extension notice will explain the standards on which your entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information, if any, you must submit. If you must provide additional information, you will be provided with at least 45 days to provide the additional information. The period from which you are notified of the additional required information to the date you respond is not counted as part of the determination period.

You have 180 days to appeal an adverse benefit determination. 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. You will be notified of the Claims Administrator’s decision upon review within a reasonable period of time, but no later than 45 days after the Claims Administrator receives your appeal request.

The 45-day period may be extended for an additional 45-day period if the Claims Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time. You will be provided with written notice prior to the expiration of the initial 45-day period. Such notice will state the special circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

CLAIMS PROCEDURES FOR GROUP HEALTH PLANS

The following claims procedures shall apply specifically to claims made under any group health plan under this Plan. To the extent that these procedures are inconsistent with the claims procedures
contained in the policies, contracts, summary plan descriptions or other written materials for the group health plan, the claims procedures in such other policies, contracts, summary plan descriptions, or other written materials shall supersede these procedures as long as such other claims procedures comply with Department of Labor Regulations 29 C.F.R. §§ 2560.503-1 and 2590.715-2719, as applicable to the Plan.

BENEFIT DETERMINATIONS

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after health 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 group health plan on which the denial is based, and provide the claim appeal procedures.

Pre-Service Claims

Pre-Service Claims are those claims that require certification or approval prior to receiving health 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 reviewing the revised Pre-Service Claim, the Claims Administrator will notify you of any additional information needed within 15 days, 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-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.

Urgent Care Claims

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 doctor with knowledge of your health condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically as soon as possible, but not later than 72 hours after the Claims Administrator receives all necessary information, or such other timeframe as required under federal law, 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 Care Claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care 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 as soon as possible, and the Claims Administrator will notify you of the determination within 24 hours after receipt of the claim, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care 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.

**Claim Denial Notices**

If your claim for benefits is denied in whole or in part, you or your beneficiary will receive notification regarding the claim denial within the applicable time period described above. This denial notice will include the reasons for the denial, reference to the Plan provision supporting the denial, a description of the Plan’s appeals procedures and other relevant information regarding the claim decision.
How to Appeal a Claim Decision

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient’s name.
- The plan identification number.
- The date(s) of health care service(s).
- The provider’s name.
- The reason(s) 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.

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 may consult with, or seek the participation of, medical experts as part of the appeal resolution process. By filing an appeal, you consent to this referral and the sharing of pertinent health 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.

APPEALS DETERMINATIONS

Pre-Service and Post-Service Claim Appeals

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

For appeals of Pre-Service Claims (as defined above), 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 the Claims Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of Post-Service Claims (as defined above), 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 the Claims Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with Urgent Care Claims, see “Urgent Care Claim Appeals” 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 the Claims Administrator. Your second level appeal request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision.

Please note that the Claims Administrator’s 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 doctor.

Urgent Care Claim Appeals

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:

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

The Claims Administrator has the exclusive right to interpret and administer the provisions of the Plan. The Claims Administrator’s decisions are conclusive and binding.

External Review

If you exhaust all internal appeals procedures, have been denied continued coverage for an ongoing course of treatment or have an urgent care claim, you may be entitled to an external review of your claim. Please consult the Plan Administrator or Claims Administrator for further details.

SUBROGATION/REIMBURSEMENT

If you file a claim for benefits for medical expenses you have incurred which may be the responsibility of a third party, you may be required to reimburse the Plan from any recovery you receive. For example, if you are injured in an automobile accident which is not your fault, you may have to repay the Plan for the health benefits you collect from the third party responsible for the accident, or from his or her insurance company, or anyone else from which you receive payment for the accident. You must notify the Plan of any claim you may have against any third party as soon as you become aware of the claim, you must sign any subrogation/reimbursement agreement requested by the Plan, and you must cooperate with the Plan in all attempts to collect from the third party. This means that the Plan has the right to act on your behalf in pursuing payment from the third party.
For additional information about subrogation/reimbursement, contact the Plan Administrator.

PLAN AMENDMENT OR TERMINATION

The Employer expects to maintain the Plan indefinitely but reserves the right to amend or terminate the Plan if the Employer believes the situation so requires. If you have elected to participate in the Plan, you will be notified in writing if there is any significant amendment or if the Plan is terminated. If the Plan is terminated, the Employer will cease deducting contributions from your salary to pay for Welfare Programs. However, all previous salary deductions will be used to pay for Welfare Programs that you have elected.

CIRCUMSTANCES THAT MAY CAUSE LOSS OF BENEFITS

The Plan contains numerous restrictions on the type and amount of benefits payable and the circumstances when paid. You should review the benefits booklets and other relevant materials for further information. You may lose coverage under the Plan if the Employer terminates the Plan or amends it to reduce or eliminate your coverage. You may forfeit the right to benefits if, among other things:

- You revoke your election to participate;
- You terminate employment with the Employer;
- You fail to make required contributions;
- You fail to file benefits claims on a timely basis;
- You make fraudulent benefit claims;
- You cease to be an eligible Employee; or
- The Plan terminates.

RESPONSIBILITY FOR GOODS/SERVICES

The Employer does not guarantee and is not responsible for the nature or quality of the goods or services provided through any health care provider or program because these goods and services are provided by personnel and agencies outside of the control of the Employer.

NO GUARANTEE OF EMPLOYMENT

The Plan is not an employment contract. Nothing contained in this document nor the benefits booklet gives you the right to be retained in the service of the Employer or interferes with the right of the Employer to discharge you or to terminate your service at any time.

STATEMENT OF ERISA RIGHTS

As a Participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan Participants shall be entitled to:
Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each Plan Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, and your Spouse and Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Spouse or Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of
Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
APPENDIX A
CHILDREN'S FRIEND & SERVICE

WELFARE PROGRAMS

The following Welfare Programs shall be treated as comprising the Plan:
ASO Navigate GIL Mod $0
Delta Dental PPO Plus Premier
Life Insurance Plan
Long-Term Disability Plan
ASO Navigate GIL Mod $750
Dependent Care Reimbursement Account (DCRA) Plan
Health Care Flexible Spending Account
UnitedHealthcare Vision
Premium Conversion Plan
In addition to Children's Friend and Service, the following Participating Employers have adopted the Plan:

There are no other employers participating in the Plan.