University of Michigan Health-Sparrow hereby establishes a Plan for payment of certain expenses for the benefit of its eligible Team Members to be known as the University of Michigan Health-Sparrow Medical Plan.

University of Michigan Health-Sparrow assures its covered Team Members that during the continuance of the Plan; all benefits hereinafter described shall be paid to or on behalf of them in the event they become eligible for benefits.

The Plan is subject to all the terms, provisions and conditions recited on the following pages hereof.

University of Michigan Health-Sparrow has caused this Plan to take effect as of 12:01 a.m. standard time on January 1, 2018, in Lansing, Michigan.

Restated effective January 1, 2019, January 1, 2020, January 1, 2023, April 1, 2024, January 1, 2025.

Teresa Znidarsic (Sep 11, 2024 08:19 EDT)

Teresa Znidarsic
SPV, CHRO, Human Resources
for University of Michigan Health-Sparrow

Dated: Sep 11, 2024

Witnessed By: Carol Fredericks
University of Michigan Health-Sparrow
Representative

Dated: Sep 11, 2024

ACCEPTANCE FOR UNIVERSITY OF MICHIGAN HEALTH-SPARROW H.S.A. PLAN FOR NON-UNION, UMH-S CLINTON HOSPITAL SEIU RN UNION, UMH-S CLINTON HOSPITAL SEIU SERVICE & TECH UNION, MNA UNION AND UAW UNION

SUMMARY PLAN DESCRIPTION
FOR
UNIVERSITY OF MICHIGAN HEALTH-SPARROW MEDICAL PLAN

UNIVERSITY OF MICHIGAN HEALTH-SPARROW H.S.A. PLAN

FOR

NON-UNION

UMH-S CLINTON HOSPITAL SEIU RN UNION

UMH-S CLINTON HOSPITAL SEIU SERVICE & TECH UNION

MNA UNION

UAW UNION

IRS PLAN NUMBER 509

PRODUCT ID: DAS03001-RX0AR308

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Effective January 1, 2018, restated effective January 1, 2019, January 1, 2020, January 1, 2023, April 1, 2024, January 1, 2025

INTRODUCTION

This Summary Plan Description has been written to provide a clear understanding of the benefits available under this Plan. The benefits as herein described take precedence over, and replace any previous literature furnished.

Except where otherwise indicated by the context, any masculine terminology used herein shall also include the feminine and vice versa, and the definition of any term herein in the singular shall also include the plural and vice versa.

The chapter, DEFINITIONS FOR THE PURPOSE OF THE PLAN shall prevail for all purposes within the Plan.

This Summary Plan Description is designed to help you understand your benefit Plan by explaining who is eligible for benefits, when you are eligible for benefits, what your benefits are, and how to file claims for your benefits.

This Summary Plan Description contains all the terms of the Plan and may be amended from time to time by the employer or alternatively may be terminated by the employer by action of its Board of Directors as to any rights, and benefits and claims of any sort which have not accrued or been incurred as of the date of amendment or termination. Any changes so made shall be binding on each covered participant and on any other covered persons referred to in this Summary Plan Description. In the case of a collectively bargained plan, these terms shall be maintained pursuant to the collectively bargained agreement, as applicable.

PROVISIONS OF THE AFFORDABLE CARE ACT (ACA)

This Plan complies with all relevant provisions of the ACA, including but not necessarily limited to the following:

- No dollar limitations on Essential Health Benefits.
- No pre-existing limitation exclusions for any covered person.
- All cost share incurred by covered persons in the form of annual deductibles, co-pays and coinsurance amounts go toward satisfaction of the annual out-of-pocket maximum, unless otherwise noted.

PROTECTED HEALTH INFORMATION (PHI), ELECTRONIC PROTECTED HEALTH INFORMATION (EPHI), AND STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) "THE PRIVACY AND SECURITY STANDARDS"

DISCLOSURE OF SUMMARY HEALTH INFORMATION (SHI) TO THE PLAN SPONSOR

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purposes of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending, or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographical information to the extent that it is aggregated by a five-digit zip code.

DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO THE PLAN SPONSOR FOR PLAN ADMINISTRATION PURPOSES

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan Document/Summary Plan Description or as required by law;
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);
- Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services (HHS), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 et seq);
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- Ensure that the adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
  - Only certain named employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed. You may contact the Plan Sponsor for a list of those persons.
  - The access to and use of PHI by the individuals described in subsection (a) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
  - In the event any of the individuals described in subsection (a) above do not comply with the provisions of the Plan Document/Summary Plan Description relating to use and disclosures of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.
  - “Plan Administration” activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. “Plan Administration” functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Document/Summary Plan Description has been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

DISCLOSURE OF CERTAIN ENROLLMENT INFORMATION TO THE PLAN SPONSOR

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

DISCLOSURE OF PHI TO OBTAIN STOP-LOSS OR EXCESS LOSS COVERAGE

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

OTHER DISCLOSURES AND USES OF PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

ELECTRONIC PROTECTED HEALTH INFORMATION (EPHI)

The Plan Sponsor agrees that with respect to any Electronic Protected Health Information disclosed to it by the Plan, or any other covered entity, the Plan Sponsor shall:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the EPHI that it creates, receives, maintains, or transmits on behalf of the Plan.
- Ensure that any agents, including a subcontractor, to whom it provides EPHI agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the Plan any security incident, as defined by the Security Rule, of which it becomes aware; and
- Ensure that adequate separation required by the Security Rule is established.

The Plan Sponsor shall only allow Team Members of the Plan Sponsor with specific classifications/designations who have been designated to carry out plan administrative functions (as indicated by the Document Signee on the Confidentiality Agreement provided by the Plan Sponsor to University of Michigan Health Service Company) access to ePHI. These specified Team Members shall only have access to and use ePHI to the extent necessary to perform those administrative functions for the Plan. In the event any of these specified Team Members do not comply with the provisions of this amendment, that Team Member shall be subject to disciplinary action by the Plan Sponsor for noncompliance pursuant to the discipline and termination procedures of the Plan Sponsor.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose health information in a manner that is inconsistent with the Security Rule.

MEDICAL PLAN REQUIREMENTS

PRE-AUTHORIZATION REQUIREMENTS

Pre-authorization is required before you or a member of your family receives certain covered services. Authorization is obtained by the provider. In general, in-network providers are responsible for obtaining authorization from the Claims Administrator before they provide these services to you.

When you choose to receive certain health services from out-of-network providers, although your provider must request and obtain the authorization from University of Michigan Health Service Company, you may be held financially responsible if it is not done. We recommend that you verify with us that your provider has requested and obtained authorization **before** you receive services.

To contact Customer Service, call the telephone number on your ID card.

If pre-authorized services differ from the services billed by your provider, University of Michigan Health Service Company's final coverage determination will be modified to account for those differences, we may only cover charges for the services that were pre-authorized.

Pre-authorization is required for the covered services below. Failure to obtain authorization may result in benefit reductions for out-of-network benefits as described below and the covered person will be responsible for any non-authorization penalties.

Covered Service	Impact on Benefits if No Pre-Authorization
Autism Spectrum Disorders treatment	No benefits will be paid.
Bariatric surgery	No benefits will be paid.
Behavioral health services – inpatient stay	The first $400.00 will not be paid.
Behavioral health services – outpatient, intermediate and residential treatment program NOTE: certain non-routine services such as intensive outpatient therapy (IOP), day treatment, partial hospitalization, residential treatment program, ECT, and neuro-diagnostic/cognitive testing require pre-authorization. Please call Customer Service for more information.	No benefits will be paid.
Dental services – accident (prior to follow up care)	No benefits will be paid.
Drugs and medications NOTE: The list of drugs and medications that require pre-authorization is subject to change. Call Customer Service for the current list.	No benefits will be paid.

Covered Service	Impact on Benefits if No Pre-Authorization
Durable medical equipment (DME) – certain items only NOTE: The list of DME subject to pre-authorization is subject to change. Call Customer Service for the current list.	No benefits will be paid.
Genetic testing	No benefits will be paid.
Home health care	No benefits will be paid.
Home infusion therapy	No benefits will be paid.
Hospice care	No benefits will be paid.
Hospital inpatient stay (including extended maternity stays and emergency admissions)	The first $400.00 will not be paid.
Inpatient or outpatient services as follows: hyperbaric oxygen therapy, spinal cord stimulation, sacral nerve stimulation, facet joint injections and facet neurotomy, TMJ surgery, orthognathic surgery, femoro-acetabular impingement hip surgery, varicose vein treatment, biofeedback training, tissue-engineered skin substitutes, blepharoplasty and repair of brow ptosis, and total cervical disc arthroplasty. NOTE: This list of services that requires pre-authorization is subject to change. Call Customer Service for the current list.	No benefits will be paid.
Preventive service – BRCA mutation testing	No benefits will be paid.
Prosthetic devices (if cost is over $1,000.00)	No benefits will be paid.
Reconstructive procedures	No benefits will be paid.
Rehabilitation – Speech Therapy (outpatient)	No benefits will be paid.
Skilled nursing facility and inpatient rehabilitation facility	No benefits will be paid.
Transplantation services	No benefits will be paid.

NOTE: You do not need authorization from the Claims Administrator or from any other person in order to obtain access to obstetrical or gynecological care from an in-network provider who specializes in obstetrics or gynecology. However, your in-network provider may be required to obtain authorization prior to certain services as described above.

ELIGIBILITY PROVISIONS

NOTE: in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this Plan may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the Plan based on the individual's participation in high risk activities (such as motorcycling, skiing and horseback riding) or any of the following health status-related factors in relation to the individual or a dependent of the individual: health status; medical condition (including both physical and mental illnesses); claims experience; receipt of health care; medical history; genetic information; evidence of insurability (including conditions arising out of acts of domestic violence); or disability.

Team Members and Dependents eligible for coverage under this Plan are not required to undergo genetic testing, nor to disclose to us whether genetic testing has been conducted or to disclose the result of genetic testing or genetic information.

TEAM MEMBER ELIGIBILITY

Eligibility for coverage under this Plan shall be based on the University of Michigan Health-Sparrow's Cafeteria/Welfare Plan documents, union membership, and employment category.

- Physicians and Team Members must complete an application for coverage within 30 days of their hire date into an eligible status.

WHEN THE TEAM MEMBER BECOMES ELIGIBLE

- Team Members commencing employment after the Plan effective date shall be eligible for medical coverage on the first of the month following date of hire.
- A Team Member who does not apply for coverage within 30 days of the date they become eligible for coverage may only have the opportunity to enroll during an announced open enrollment period, except when a Team Member loses other medical coverage or experiences a qualifying event.
- A Team Member who applies for coverage due to loss of other medical coverage or a qualifying event is required to furnish the required documentation and must apply within 30 days of the qualifying event.
- If a Team Member transfers into a benefit eligible position, they must apply for coverage within 30 days of the transfer date. Coverage will be effective the first of the month following their transfer date into the benefit eligible position.

NOTICE OF SPECIAL ENROLLMENT PERIOD

You and/or your dependents may be able to enroll during a special enrollment period. A special enrollment period is not available to you and your dependents if coverage under a prior plan was terminated for cause, or because premiums were not paid on a timely basis.

You and/or your dependents do not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to you and/or your dependents even if COBRA is not elected.

If you are declining enrollment for yourself or your dependents (including your spouse), you must provide the reason for declining coverage in writing. If written notice is not

provided, a special enrollment period may not be provided to you or your dependents in the following circumstances:

- **An Event Takes Place**. A special enrollment period applies to you and any of your dependents when one of the following events occurs:
  - Birth.
  - Legal Adoption.
  - Placement for adoption.
  - Marriage.

Following one of the above events, coverage begins on the date of the event if coverage is applied for within 30 days of the event.

- **Missed Initial Enrollment Period or Open Enrollment Period.** A special enrollment period applies for you and/or your dependents who did not enroll when first eligible for coverage or during an announced open enrollment if the following are true:
  - You and/or your dependents loses eligibility under a Medicaid plan or state children's health insurance program (CHIP); or
  - You and/or your dependent gains eligibility for a premium assistance subsidy under Medicaid or a CHIP (subsidy to be used toward payment of premiums for a group health plan); or
  - You and/or your dependents had existing health coverage under another plan at the time there was an opportunity to enroll when first eligible for coverage or during an announced open enrollment and coverage under the prior plan ended because of any of the following:
    - Loss of eligibility (including, but not limited to, legal separation, divorce or death).
    - The employer stopped paying the contributions. This is true even if you and/or your dependents continue to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
    - In the case of COBRA continuation coverage, the coverage ended.

In the case of loss of eligibility under a Medicaid plan or state CHIP or gaining eligibility for a premium assistance subsidy under Medicaid or a CHIP, coverage begins on the day immediately following the day coverage under Medicaid ends or you become eligible for premium assistance if you apply for coverage within 60 days of the event.

In the case of loss of coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends if you apply for coverage within 30 days of the event.

To request special enrollment or obtain more information, contact:

Human Resources
University of Michigan Health-Sparrow
1200 East Michigan Avenue
Suite 235
Lansing, Michigan 48912
517-364-5333

WHEN TEAM MEMBER COVERAGE IS TERMINATED

The coverage of any Team Member shall automatically cease at the earliest time indicated below, except as provided in the Continuation of Benefits (COBRA) provision:

- The last day of the calendar month in which employment terminates;
- The last day of the calendar month in which the Team Member ceases to be in a class of Team Members eligible for coverage;
- The last day of the calendar month in which the Team Member fails to make any required contribution for coverage;
- Date Plan is terminated;
- The last day of the calendar month in which the employer terminates Team Member's coverage;
- Day after the Team Member dies.

WHEN THE TEAM MEMBER MAY CONTINUE BENEFIT COVERAGE

Benefit coverage may be continued for all benefits:

- Up to 12 weeks during an approved leave of absence that qualifies under the Family and Medical Leave Act of 1993.
- Up to the end of the third month following the date a disability begins if the Team Member becomes totally disabled, and the leave does not qualify under the Family and Medical Leave Act of 1993.
- Up to the end of the month in which layoff occurs if such Team Member is temporarily laid off.
- Up to the end of the month of an approved leave of absence that is not addressed in "1," "2" or "3" above.

NOTE**:** A leave that qualifies under the Family and Medical Leave Act of 1993 (FMLA) will not be applied toward the continuation period available under COBRA. Any other period of leave that does not qualify under the FMLA may apply toward the continuation period available under COBRA if a Qualifying Event (as defined by COBRA) occurs at the time of leave, or during the period of leave.

No benefits are payable for charges incurred after an individual's benefit coverage ends.

TEAM MEMBERS ON MILITARY LEAVE

Team Members going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA). These rights include up to 24 months of extended coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage with no pre-existing condition limitation applied upon return from service. These rights apply only to Team Members and their dependents covered under the Plan before leaving for military service.

Plan exclusions and waiting periods may be imposed for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

SPOUSAL ACCESS PROVISION

Spouses of Team Members working for an employer other than University of Michigan Health-Sparrow who have health insurance available for which they are not required to pay premiums costing more than the established threshold amount for single coverage, are only eligible to be covered by the University of Michigan Health-Sparrow Medical Plan if they are enrolled in their employer's health coverage.

Call UMH-S Human Resources Office for the current monthly and yearly threshold amounts.

If a Team Member elects to cover a spouse who is required to take coverage through their employer, this Plan becomes secondary coverage for the spouse, subject to coordination of benefits as provided in the applicable plan.

Dependents may be covered by either the Team Member's or spouse's health plan, subject to coordination of benefits as provided in the applicable plan.

WHEN THE DEPENDENT BECOMES ELIGIBLE

- Eligible dependents include a spouse and any married or unmarried child of you or your spouse until the end of the calendar month in which they turn 26.

A child may be covered to any age if "totally and permanently" disabled by either a physical or mental disability that occurred prior to age 26 as described under the section entitled, WHEN DEPENDENT COVERAGE IS TERMINATED.

- Coverage for a dependent will be effective on the date the Team Member's coverage becomes effective if he applies for dependent coverage when he enrolls in the Plan. In no event will the Team Member's dependents be covered before the date the Team Member's coverage begins. A Team Member without a dependent on the date he becomes eligible for coverage who later acquires a dependent may enroll his dependent in this Plan by written application within 30 days after he acquires that dependent.

A newborn child, adopted child, or child placed for adoption will be covered if enrolled within the 30 day period following birth, adoption, or adoption placement.

This Plan is intended to comply with the Omnibus Budget Reconciliation Act of 1993 (OBRA) with respect to dependent child eligibility and Qualified Medical Child Support Orders.

- If coverage for a dependent (including newborns, adopted children, or children placed for adoption) is applied for more than 30 days following the date that dependent becomes eligible for coverage, the dependent may only have the opportunity to enroll during an announced open enrollment period.

WHEN DEPENDENT COVERAGE IS TERMINATED

Under COBRA, it is the responsibility of the Team Member or a family member to inform the employer of a divorce, judgment of separate maintenance, legal separation, or a child

losing dependent status (e.g., student dependent status), within 60 days of the Qualifying Event.

The coverage of any covered dependent shall automatically cease at the earliest time indicated below, except as provided in any Continuation of Benefits (COBRA) provision:

- The last day of the calendar month in which the Team Member's employment terminates;
- The last day of the calendar month in which the Team Member ceases to be in a class of Team Members eligible for coverage;
- The last day of the calendar month in which the Team Member fails to make any required contribution for coverage;
- Date Plan is terminated;
- The last day of the calendar month in which the employer terminates Team Member's coverage;
- The last day of the calendar month in which the Team Member dies;
- The last day of the calendar month in which the dependent loses his eligible status as defined herein:
  - For spouses:
    - Date of separation (if applicable within your State); or
    - Date of divorce; or
    - Upon failure to comply with spousal access provision of this Plan.
  - For children:
    - The date on which your Eligible Dependent ceases to meet any of the dependent eligibility requirements, as specified in this document or the Supplemental Plan Documents. For example, your Spouse's Health Plan coverage will be terminated at 11:59 p.m. on the date on which you cease to be married to him or her and your Child's Health Plan coverage will be terminated at 11:59 p.m. on the date he or she ceases to be considered your child (e.g., he or she is no longer your step-child upon your divorce from the child's parent or the child is no longer considered your legal guardian upon attaining age 18 or, if earlier, when the guardianship order expires). However, if your Child is losing active coverage under the Health Plan due to attaining age 26, such Child's coverage will end as of the last day of the calendar month.

If two Team Members under this Plan are married, they may be covered under this Plan as both a Team Member and a dependent. Eligible dependent children of two covered Team Members may be enrolled as dependents of both Team Members, whether the Team Members are married or unmarried.

This Plan will coordinate benefits between the two plans following the guidelines as described in the chapter, COORDINATION OF BENEFITS.

OTHER EVENTS ENDING COVERAGE

When any of the following happen, this Plan will provide written notice to the Team Member that coverage has ended on the date identified in the notice:

- An act, practice or omission that constituted fraud related to the Plan, or an intentional misrepresentation of material fact related to the Plan. Examples include providing false information or withholding accurate information relating to eligibility for you or for a Dependent. This list is not exhaustive. Termination of this Policy for these purposes may be retroactive to the effective date of coverage or to some other date. During the first three years the Plan is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.
- Material violation of the terms of the Plan.
- Improper use of ID card by a Team Member who permitted an unauthorized person to use the Team Member’s ID card, or Team Member used another person's card. Such an act may lead to retroactive termination of coverage under this Plan back to the date the fraud occurred.
- Team Member or covered dependents committed acts of physical or verbal abuse that pose a threat to University of Michigan Health Service Company staff, a provider, or other covered persons (will be reviewed on a case-by-case basis for continued coverage under the Plan).

NOTE: Coverage under this Plan can only be rescinded in cases of fraud or intentional misrepresentation of material fact and a 30-day written notice will be given prior to rescission of coverage.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

The Plan Administrator shall adhere to the terms of any medical child support order that satisfies the requirements of this Section and Section 609 of ERISA. A medical child support order is any judgment, decree, or order (including a court approved property settlement agreement) issued by a court of competent jurisdiction, which (a) relates to the provision of child support with respect to the child of a Participant under a group health plan (including this Plan) or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to medical benefits under the Plan, or (b) enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13623 of the Omnibus Budget Reconciliation Act of 1993) with respect to the Plan, and which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to receive benefits payable with respect to a Participant or beneficiary under the Plan. For purposes of this Section, an "alternate recipient" shall mean any child of a Participant who is recognized by a medical child support order as having a right to enrollment under this Plan with respect to the Participant.

A Qualified Medical Child Support Order must clearly specify: (a) the name and last known mailing address of the Participant and the name and mailing address of each alternate recipient covered by the order; (b) a reasonable description of the type of coverage to be provided under the Plan to each such alternate recipient, or the manner in which such type of coverage is to be determined; (c) the period to which such order applies; and (d) each plan to which such order applies.

Any Qualified Medical Child Support Order shall not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13623 of the Omnibus Budget Reconciliation Act of 1993).

The Plan Administrator shall promptly notify the Participant and each alternate recipient of the receipt of a medical child support order by the Plan and the Plan's procedures for determining the "qualified" status of medical child support orders. Within a reasonable period after receipt of a medical child support order, the Plan Administrator shall determine whether the order is a Qualified Medical Child Support Order and shall notify the Participant and each alternate recipient of this determination. If the Participant or any affected alternate recipient disagrees with the determinations of the Plan Administrator, the disagreeing party shall be treated as a claimant and the claims procedure of the Plan shall be followed. The Plan Administrator may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the Plan.

Alternate recipients of a Qualified Medical Child Support Order shall be treated as beneficiaries under the Plan for all purposes of ERISA.

Payments under this Plan pursuant to a Qualified Medical Child Support Order in reimbursement for expenses paid by the alternate recipient or the alternate recipient's

custodial parent or legal guardian shall be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian.

SPARROW PROVIDER NETWORK (SPN) AND SPARROW CARE NETWORK (SCN)

University of Michigan Health-Sparrow has contracted with Sparrow Provider Network (SPN) and Sparrow Care Network (SCN). SPN and SCN provide a network of community-based physicians, hospitals, and other approved providers, dedicated to providing quality medical care.

Refer to the SPN and SCN provider directories for a list of participating providers. For the most up to date information, you can access the online provider directories through the UMH-S Intranet. Periodic updates of the network will be available in the UMH-S Human Resources Office, or by contacting SPN directly at 517-364-8150.

The following describes some important aspects of the Plan. Please take a moment to familiarize yourself with these concepts.

This Plan provides two levels of benefits:

- In-network.
- Out-of-network (providers who do not participate in either network).

In-network providers are those that participate in the SPN or SCN networks. This Plan permits the patient to choose services from in-network or out-of-network benefit levels on a case-by-case basis depending upon the network status of the provider you choose. You can access the in-network benefit levels by seeking treatment from a provider that participates with SPN or SCN.

Enrolled females may also choose an OB-GYN physician in addition to their PCP for all obstetrical and gynecological services. PCPs can assist you to coordinate and manage your routine medical care and health maintenance and your care during an illness.

No referral is required from your PCP for treatment by a SPN or SCN specialist; however, some specialists may require a referral from your PCP before you can make an appointment.

REFERRAL TO AN OUT-OF-NETWORK SPECIALIST

Together the Sparrow Provider Network (SPN) and the Sparrow Care Network (SCN) are developed to take care of most of your medical needs. However, occasionally your SPN or SCN physician or an out-of-network provider may refer you to a specialist or facility that does not participate with SPN or SCN.

A referral by your provider to an out-of-network specialist or facility must be authorized by University of Michigan Health Service Company to be covered at the in-network benefit level. Otherwise, this will be considered an out-of-network service and will be covered as such.

Authorization to cover at the in-network level will be given only in a medical situation in which appropriate services are not available in the SPN or SCN network.

RETROACTIVE REFERRALS TO AN OUT-OF-NETWORK SPECIALIST

Retroactive referrals to a non-SPN or non-SCN specialist will not be accepted. Referrals authorized more than two business days after the patient has received services are considered retroactive. Retroactive referrals are considered out-of-network services.

THE FOLLOWING EXPENSES ARE ALWAYS CONSIDERED IN-NETWORK:

- Eligible services provided by a SPN or SCN participating provider.
- Eligible services that are referred out-of-network by your SPN or SCN participating provider and approved by University of Michigan Health Service Company.
- Eligible services that are provided in a hospital emergency department as a result of an accident or emergent illness.

Emergent illness is defined as severe symptoms occurring suddenly and unexpectedly which could reasonably be expected to result in serious physical impairment or loss of life or could seriously jeopardize a covered person's health if not treated immediately.

- Ambulance services.
- Urgent care center visits.
- If a SPN or SCN physician admits you to an SPN or SCN hospital, all physician expenses associated with that referral will be considered in-network.

THE FOLLOWING EXPENSES WILL BE CONSIDERED OUT-OF-NETWORK:

- Eligible services that are provided by a non-SPN or non-SCN participating physician, except as allowed above.
- Refusal of transfer from a non-SPN or non-SCN hospital to a participating SPN or SCN hospital. Transfers will only be made if medically necessary.

ZELIS HEALTHCARE TRAVEL NETWORK

University of Michigan Health Service Company on behalf of University of Michigan Health-Sparrow and its subsidiaries has contracted with Zelis Healthcare (formerly GlobalCare) to provide a travel network. Zelis Healthcare contracts with multiple Preferred Provider Organizations (PPOs) to provide nationwide coverage of providers that are willing to provide discounted services.

The Zelis Healthcare travel network provides discounted services at participating providers **that are outside of the SPN/SCN service area**. If you are receiving services from one of these providers, please present your SPN/SCN identification card that includes the Zelis Healthcare affiliate logo(s). Eligible services are covered at the out-of-network benefit level as shown in the Schedule of Benefits.

If you need medical attention while traveling outside of the SPN/SCN service area, please call Zelis Healthcare at 866-807-6193 for assistance locating a provider for discounted services.

Students away at school or dependents living with a custodial parent may also utilize the travel network. Your dependent can locate a provider to receive discounted services by calling Zelis Healthcare if outside the SPN/SCN service area.

Providers should send itemized bills to:

ZELIS HEALTHCARE
EDI PAYOR ID: 07689
PO BOX 247
ALPHARETTA GA 30009-2047

MEDICAL EXPENSE BENEFITS

ANNUAL DEDUCTIBLE AMOUNTS

In-Network

This Plan has an individual annual deductible amount and a family annual deductible amount that applies to most charges (see the chapter, MEDICAL SCHEDULE OF BENEFITS for specific amounts).

If you have single coverage, you must satisfy the individual annual deductible amount. If you have covered dependents, the family annual deductible amount must be satisfied. Family members may incur expenses in varying amounts. As soon as the family annual deductible is collectively satisfied, the in-network coinsurance percentage rate will apply to any covered family members.

The following out-of-pocket expenses are not subject to and do not go toward satisfaction of the annual in-network deductible:

- Expenses in excess of reasonable and customary.
- Any penalty for failure to comply with any of the required cost containment provisions of the Plan.
- Preventive services.

Out-of-Network

This Plan has an individual annual deductible amount and a family annual deductible amount when out-of-network providers are used. These are shown in the Schedule of Benefits. The annual deductible is waived for emergency or urgent care.

If you have single coverage, you must satisfy the individual annual deductible amount. If you have covered dependents, the family annual deductible amount must be satisfied. Family members may incur expenses in varying amounts. As soon as the family annual deductible is collectively satisfied, the out-of-network coinsurance percentage rate will apply to any covered family members.

The following out-of-pocket expenses will not be applied toward the satisfaction of the annual out-of-network deductible:

- Expenses in excess of reasonable and customary.
- Any penalty for failure to comply with any of the required cost containment provisions of the Plan.
- Prescription drug co-pays.

FULL PAYMENT PROVISION

There are separate in-network and out-of-network annual out-of-pocket maximums. For single coverage, once an individual has satisfied the individual annual out-of-pocket maximum shown in the Schedule of Benefits, additional eligible charges will be paid on the covered individual at 100% of eligible expenses for the balance of the calendar year, unless otherwise noted. For family coverage, the entire family annual out-of-pocket maximum shown in the Schedule of Benefits must be satisfied before additional eligible

charges will be paid on covered persons at 100% of eligible expenses for the balance of the calendar year, unless otherwise noted.

There are some out-of-network benefits that do not go toward satisfaction of the annual out-of-pocket maximum and these are noted below as well as in the chapter, MEDICAL SCHEDULE OF BENEFITS.

The following expenses do not apply toward the annual out-of-pocket maximum:

- Expenses for services or supplies that are not covered under this Plan.
- Penalty for failure to comply with a required provision of the Plan.
- Expenses in excess of reasonable and customary.

MEDICAL SCHEDULE OF BENEFITS

PAYMENT INFORMATION

PAYMENT TERM	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible:	$1,650.00 for single coverage $3,300.00 for family coverage	$3,000.00 for single coverage $6,000.00 for family coverage
Annual Out-of-Pocket Maximum:	$3,000.00 for single coverage $6,000.00 for family coverage	$6,250.00 for single coverage $12,500.00 for family coverage

The annual deductible and annual out-of-pocket maximum amounts for qualified High Deductible Health Plans are indexed annually by the U.S. Treasury Department and may change due to a cost-of-living adjustment. The annual deductible and annual out-of-pocket maximum amounts shown above may be changed to match the indexed amounts published by the U.S. Treasury Department. You will be notified in writing no less than 30 days before the effective date of a change in these amounts.

If you have single coverage, you must satisfy the annual deductible and annual out-of-pocket amounts. If you have family coverage under the Policy, the single coverage annual deductible and annual out-of-pocket maximum amounts shown above do not apply. For family coverage, the family annual deductible and annual out-of-pocket maximum amounts must be satisfied.

The University of Michigan Health-Sparrow-provided HSA will cover up to $750.00 for single coverage or up to $1,500.00 for family coverage of your cost share under this Plan. Team Members who start after the first of the year may receive a prorated contribution amount. Please contact HR for specifics.

NOTE: This Plan does not contain an annual or lifetime limit on the dollar amount of Essential Health Benefits.

BENEFIT INFORMATION

BENEFIT	COVERAGE	PLAN REQUIREMENTS, LIMITS, PROVISIONS
Ambulance	IN-NETWORK 100% after deductible OUT-OF-NETWORK Same as in-network benefit	
Autism Spectrum Disorders Treatment	IN-NETWORK 100% after deductible OUT-OF-NETWORK Not covered	Pre-authorization is required for coverage of Autism Spectrum Disorders treatment.
Bariatric Surgery	IN-NETWORK 100% after deductible OUT-OF-NETWORK Not covered	Pre-authorization is required for coverage of bariatric surgery.
Behavioral Health Treatment (inpatient services)	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	Pre-authorization is required for coverage of inpatient behavioral health hospital admissions. NOTE: Benefits for Professional Fees are covered elsewhere in this Schedule.
Behavioral Health Treatment (Residential treatment program and intermediate services)	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	Pre-authorization is required for coverage of residential treatment programs and intermediate treatment. NOTE: Benefits for Professional Fees are covered elsewhere in this Schedule.
Behavioral Health Treatment (outpatient services)	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	Coverage of certain non-routine outpatient services such as intensive outpatient therapy (IOP), ECT, and neuro-diagnostic/cognitive testing requires pre-authorization.

BENEFIT	COVERAGE	PLAN REQUIREMENTS, LIMITS, PROVISIONS
Chemotherapy and Radiation Therapy (outpatient)	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	NOTE: Benefits for Professional Fees are covered elsewhere in this Schedule.
Clinical Trials	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	NOTE: It is advised that you or your provider call Customer Service prior to receiving services to determine if they are covered under this Plan.
Compression Stockings (prescribed for vascular conditions)	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	Combined in-network and out-of-network calendar year maximum benefit for covered compression stockings: three pair per covered person.
Convenience Care Facility Visit (such as UM Health-Sparrow Walk-In Care)	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	
Dental Services (limited to accidental injury and dental anesthesia services with associated hospital and facility charges)	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	Pre-authorization is required prior to follow-up treatment for coverage of accidental dental services.
Diagnostic X-Ray and Laboratory - Outpatient (including ultrasounds, high tech radiology/advanced imaging and nuclear medicine)	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	NOTE: Benefits for Professional Fees are covered elsewhere in this Schedule.
Durable Medical Equipment (DME)	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	Pre-authorization is required for coverage of certain items of DME such as implantable insulin and infusion pumps, bone stimulators, power wheelchairs and/or mobility devices, automatic

BENEFIT	COVERAGE	PLAN REQUIREMENTS, LIMITS, PROVISIONS
		external defibrillators, and chest wall oscillation vests. Call Customer Service for current information.
Emergency Department Visits (accident and illness)	IN-NETWORK 100% after deductible OUT-OF-NETWORK Same as in-network benefit	NOTE: You do not have to obtain pre-authorization before you receive care or treatment at an emergency department. Pre-authorization is required for coverage if admitted for an inpatient stay.
Genetic Testing	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	Pre-authorization is required for coverage of genetic testing services.
Health Education Counseling (in-network only)	IN-NETWORK 100%, deductible waived OUT-OF-NETWORK Not covered	In-network calendar year maximum: three sessions per covered person.
Hemodialysis (outpatient)	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	NOTE: Benefits for Professional Fees are covered elsewhere in this Schedule.
Home Health Care	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	Pre-authorization is required for coverage of home health care services. Combined in-network and out-of-network maximum benefit: 60 visits per covered person per calendar year..
Home Infusion Therapy	IN-NETWORK 100% after deductible OUT-OF-NETWORK	Pre-authorization is required for coverage of home infusion therapy.

BENEFIT	COVERAGE	PLAN REQUIREMENTS, LIMITS, PROVISIONS
	70% R&C after deductible	
Hospice Care	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	Pre-authorization is required for coverage of hospice care.
Infertility Services (to treat the underlying medical conditions that result in infertility).	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	Services designed to create a pregnancy are not covered.
Injections and Infusions (received in a physician's office, including allergy injections/serum and specialty injections/infusions)	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	Pre-authorization is required for coverage of certain drugs and medications. The list of these drugs and medications is subject to change. Call Customer Service for more information.
Inpatient Hospital Expenses (other than for behavioral health), Including: • Ward or Semi-Private Room • Miscellaneous Hospital Charges • Intensive Care Units • Diagnostic X-Ray and Laboratory • Radiation Therapy and Chemotherapy • Physical, Speech, or Occupational Therapy • Pregnancy Benefits (facility charges)	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	Pre-authorization is required for coverage of inpatient hospital stays.
Medical Supplies (including diabetic supplies)	IN-NETWORK 100% after deductible	

BENEFIT	COVERAGE	PLAN REQUIREMENTS, LIMITS, PROVISIONS
	OUT-OF-NETWORK 70% R&C after deductible	
Nutritional Education Counseling for preventive health services only (in-network only)	IN-NETWORK 100%, deductible waived OUT-OF-NETWORK Not covered	
Ostomy Supplies	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	
Outpatient Hospital Expenses	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	Hyperbaric oxygen therapy, spinal cord stimulation, sacral nerve stimulation, facet joint injections and facet neurotomy, TMJ surgery, orthognathic surgery, femoro-acetabular impingement hip surgery, varicose vein treatment, biofeedback training, tissue-engineered skin substitutes, blepharoplasty and repair of brow ptosis, and total cervical disc arthroplasty require prior authorization.
Physician Office Visit by PCP or Specialist (for injury and illness)	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible If due to emergent/urgent condition outside the SPN/SCN service area: 100% R&C after deductible	
Pregnancy Services (prenatal, postnatal and delivery charges)	IN-NETWORK 100% after deductible OUT-OF-NETWORK	

BENEFIT	COVERAGE	PLAN REQUIREMENTS, LIMITS, PROVISIONS
	70% R&C after deductible	
Pregnancy Termination	IN-NETWORK 100% after deductible OUT-OF-NETWORK Same as in-network benefit	Combined in-network and out-of-network lifetime maximum benefit: one pregnancy termination per covered person.
Prescription Drugs - Outpatient	IN-NETWORK All UMH-S* and Express Scripts Pharmacies <u>Up to a 34-Day Supply:</u> Preferred Blood Glucose Testing Strips – 100%, deductible waived Generic – 100% after a $10.00 co-pay per prescription after deductible Preferred Brand – 100% after a $40.00 co-pay per prescription after deductible Non-Preferred Brand – 100% after a $80.00 co-pay per prescription after deductible Non-Preferred Blood Glucose Testing Strips – 100% after a $80.00 co-pay per prescription Non-Preferred Specialty – 100% after a $100.00 co-pay per prescription after deductible <u>35-Day Supply up to 90-Day Supply:</u> Generic – 100% after a $20.00 co-pay per prescription after deductible Preferred Brand – 100% after a $80.00 co-pay per prescription after deductible Non-Preferred Brand – 100% after a $160.00 co-pay per prescription after deductible Non-Preferred Specialty – Not available OUT-OF-NETWORK	*UMH-S Pharmacy locations. All Specialty Drugs regardless of tier placement are only available in up to a 34-day supply. Pre-authorization is required for coverage of certain drugs and medications. Call Customer Service for the current list. This list is subject to change.

BENEFIT	COVERAGE	PLAN REQUIREMENTS, LIMITS, PROVISIONS
	Covered with applicable in-network co-pay **only** if incurred outside the SPN/SCN service area due to accident, emergent illness or urgent condition; otherwise not covered.	
Preventive Health Services (including office visits, vaccines laboratory tests and x-ray charges – in-network only)	IN-NETWORK 100%, deductible waived OUT-OF-NETWORK Not covered	Pre-authorization is required for coverage of BRCA mutation testing.
Professional Fees for Surgical and Medical Services – Inpatient and Outpatient (includes assistant surgeon, attending physician and physician consultation)	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	
Prosthetic Appliances (functional and non-functional)	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	Pre-authorization is required for coverage of prosthetic devices if cost is over $1,000.00.
Reconstructive Procedures	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	Pre-authorization is required for coverage of reconstructive procedures.
Rehabilitation Therapy (outpatient) • Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST), Pulmonary Therapy • Cardiac Rehabilitation (phase II only)	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	Pre-authorization is required for coverage of outpatient Speech Therapy. Combined in-network and out-of-network maximum benefit: 36 visits total for PT, OT, ST & pulmonary therapy per covered person per calendar year. Combined in-network and out-of-network maximum benefit: 36 visits for cardiac rehabilitation per

BENEFIT	COVERAGE	PLAN REQUIREMENTS, LIMITS, PROVISIONS
		covered person per calendar year.
Shoe Orthotics/Orthopedic Shoes/Diabetic Shoes and Inserts	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	Combined in-network and out-of-network limits: Shoe orthotics are limited to one pair every three years per covered person. Orthopedic shoes are limited to one pair per lifetime per covered person. Diabetic shoes are limited to one pair per calendar year per covered person. Diabetic shoe inserts are limited to three pair per calendar year per covered person.
Skilled Nursing Facilities and Inpatient Rehabilitation Facilities	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	Pre-authorization is required for coverage of skilled nursing facility and inpatient rehabilitation facility services. Combined in-network and out-of-network maximum benefit for skilled nursing facilities and inpatient rehabilitation facilities: 100 days per covered person per calendar year.
Spinal Treatment Services (including x-rays)	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	Combined in-network and out-of-network calendar year maximum benefit for spinal manipulation services: 24 visits per covered person.
Surgical Brassieres (following mastectomy)	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	Combined in-network and out-of-network calendar year maximum benefit: three brassieres per covered person.

BENEFIT	COVERAGE	PLAN REQUIREMENTS, LIMITS, PROVISIONS
Surgical Sterilization – Female (and all related charges)	IN-NETWORK 100%, deductible waived OUT-OF-NETWORK 70% R&C after deductible	
Surgical Sterilization - Male	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	
Telemedicine Services	IN-NETWORK 100% after deductible OUT-OF-NETWORK 70% R&C after deductible	
Tobacco Cessation Program NOTE: Preferred Tobacco Cessation Products are covered under your Prescription Drug Plan at no cost share to you.	IN-NETWORK 100%, deductible waived OUT-OF-NETWORK Not covered	Call Customer Service for details.
Transplantation Services (at Designated Facilities only)	IN-NETWORK 100% after deductible OUT-OF-NETWORK Not covered	Pre-authorization is required for coverage of transplantation services.
Urgent Care Facility Visit	IN-NETWORK 100% after deductible OUT-OF-NETWORK Same as in-network benefit	
Weight Management Services	IN-NETWORK 100% after deductible OUT-OF-NETWORK Not covered	
Wig or Hairpiece (following chemotherapy or radiation treatment)	IN-NETWORK 100% after deductible OUT-OF-NETWORK	Combined in-network and out-of-network lifetime maximum benefit for a covered wig or hairpiece:

BENEFIT	COVERAGE	PLAN REQUIREMENTS, LIMITS, PROVISIONS
	70% R&C after deductible	$100.00 per covered person.

ELIGIBLE MEDICAL EXPENSES

1. AMBULANCE (ground, water or air)

The Plan covers medically necessary professional ground ambulance service to the nearest local hospital equipped to furnish treatment for the patient's sickness or injury.

Air or water ambulance transport by a licensed ambulance service is covered when there is a potentially life-threatening condition that does not permit the use of another form of transportation. The condition must be such that the time needed to transport the covered person by ground, or the instability of transportation by ground, poses a threat to the survival or seriously endangers the covered person's health. Transportation must be to the nearest Hospital where appropriate treatment of the condition can be performed. The list below includes examples of medical conditions in which air ambulance transport may be necessary. This list does not guarantee coverage nor is it intended to be all inclusive. Diagnosis alone does not guarantee coverage.

- Intracranial bleeding requiring neurosurgical intervention
- Cardiogenic shock
- Burns requiring treatment in a burn center
- Conditions requiring treatment in a hyperbaric Oxygen unit
- Multiple severe injuries
- Life-threatening trauma

The covered person's symptoms at the time of transport must meet University of Michigan Health Service Company's established criteria for coverage. We may ask for verification by requesting the records of the attending physician and the ambulance company.

For air or water ambulance transport:

- The patient must have a potentially life-threatening condition and transport by ground ambulance poses a threat to your survival or seriously endangers the patient's health.
- No other means of transportation are available.
- The provider is not a commercial entity.
- The patient is taken must be to the nearest facility capable of treating the patient's condition.

Air or water ambulance services are not covered for transport to a facility that is not an acute care hospital. Transport to a nursing facility, a physician's office, or your home by air or water ambulance is not covered.

The Plan covers non-emergency medically necessary ambulance transportation by a licensed ambulance service between facilities when the following criteria are met:

- The patient's condition must be such that any other form of transportation would be medically contraindicated; and
- Any of the following circumstances exists:

- Transfer from an acute care facility to a patient's home or skilled nursing facility; or
- Transfer to and from a patient's home to an acute care facility to obtain medically necessary diagnostic or therapeutic services (such as MRI, CT scan, dialysis, etc.).

- Transportation to or from one acute care facility to another acute care facility, skilled nursing facility or free-standing dialysis center in order to obtain medically necessary diagnostic or therapeutic services (such as MRI, CT scan, intensive care services including neonatal ICU, acute interventional cardiology, radiation therapy, etc.), provided such services are:
  - Not available at the transferring facility where the patient is being treated; and
  - The patient cannot be safely transported in another way; and
  - The patient requires continued acute inpatient medical care.
- Ground ambulance for a deceased patient in the following circumstances:
  - The patient was pronounced dead while in route or upon arrival at the hospital or final destination; or
  - The patient was pronounced dead by a legally authorized individual (physician or medical examiner) after the ambulance call was made, but prior to pick-up.

2. AUTISM SPECTRUM DISORDERS TREATMENT

The Plan covers the diagnosis and treatment of certain Autism Spectrum Disorders when pre-authorization has been received.

Diagnosis of Autism Spectrum Disorders includes assessments, evaluations, or tests, including the autism diagnostic observation schedule, performed by a licensed in-network physician or a licensed in-network psychologist to diagnose whether an individual has one of the Autism Spectrum Disorders.

Treatment of covered Autism Spectrum Disorders involves medically necessary, evidence-based treatment that includes the following care prescribed or ordered for an individual diagnosed with one of the Autism Spectrum Disorders by a licensed in-network physician, licensed in-network psychologist or board certified in-network behavioral analyst:

Behavioral health treatment (evidenced-based counseling and treatment programs, including applied behavioral analysis [ABA], that are both 1) necessary to develop maintain, or restore, to the maximum extent practicable, the functioning of an individual; and 2) are provided or supervised by a board certified in-network behavior analyst or a licensed in-network psychologist so long as the services performed are commensurate with the psychologist's formal university training and supervised experience);

- Pharmacy management (medically necessary services related to medications prescribed by an in-network physician to determine the need or effectiveness of the medications);
- Psychiatric care (evidence-based direct or consultative services provided by an in-network psychiatrist licensed in the state in which the psychiatrist practices);

- Psychological care (evidence-based direct or consultative services provided by an in-network psychologist licensed in the state in which the psychologist practices);
- Therapeutic care (evidence-based services provided by a licensed or certified in-network speech therapist, in-network occupational therapist, in-network physical therapist, or in-network social worker).

University of Michigan Health Service Company may:

- Require submission of an autism treatment plan for review;
- Require submission of results of the autism diagnostic observation schedule that has been used in the diagnosis of an Autism Spectrum Disorder;
- Request that an annual development evaluation be conducted and the results of that annual development evaluation be submitted to us.

3. BARIATRIC SURGERY

Bariatric surgery must be received in a hospital on an inpatient basis at University of Michigan Health-Sparrow Hospital.

Benefits include facility charges, medical supplies and other non-physician services, surgery, and professional fees.

Coverage of bariatric surgery requires pre-authorization and you must meet criteria for coverage. Contact Customer Service for criteria that must be met to qualify for the bariatric surgery benefit.

The Plan does not cover:

- Services for bariatric surgery received from a facility other than University of Michigan Health-Sparrow Hospital.
- Bariatric surgery more than once per lifetime unless done to correct or reverse complications from a previous bariatric surgery.

4. BEHAVIORAL HEALTH TREATMENT (inpatient, residential treatment program, intermediate/day treatment/partial hospitalization or outpatient)

The Plan covers medically necessary behavioral health services received on an inpatient, intermediate/day treatment or outpatient care basis in a provider's office, a hospital or at an alternate facility (depending on the service provided) when pre-authorization has been received, if required, including:

- Mental health, alcoholism, chemical dependency, or substance use disorder evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, and group therapeutic services (including intensive outpatient therapy)

- Crisis intervention.
- Residential treatment program.
- Inpatient detoxification from abusive chemicals or substances that is limited to medical services for physical detoxification when necessary to protect your physical health and well-being

Covered treatment settings are as follows:

- Acute Inpatient Hospitalization and Detoxification – the highest level of intensity of medical and nursing services provided within a structured environment providing 24-hour skilled nursing and medical care. Full and immediate access to ancillary medical care must be available for those programs not housed within general medical centers. An inpatient stay is covered at the semi-private room rate.
- Residential Treatment Program – a program that provides medically or clinically supervised therapies in a 24-hour setting and that is designed to treat groups of patients with similar mental health conditions or substance use dependency.
- Intermediate/Day Treatment/Partial Hospitalization – an intensive, non-residential level of service where multidisciplinary medical and nursing services are required. This care is provided in a structured setting, similar in intensity to inpatient, meeting for more than four hours (and generally less than eight hours) daily.
- Intensive Outpatient Treatment – multidisciplinary, structured services provided at a greater frequency and intensity than routine outpatient treatment. These are generally up to four hours per day, up to five days per week. Common treatment modalities include individual, family, group, and medication therapies.
- Outpatient/Ambulatory Detoxification – detoxification services delivered within a structured program having medical and nursing supervision where physiological consequences of withdrawal have non-life-threatening potential.
- Outpatient Treatment – the least intensive level of service, typically provided in an office setting from 45-50 minutes (for individuals) to 90 minutes (for group therapies) per day.
- Observation – a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital or facility. It is indicated for those situations where full criteria for inpatient hospitalization are not met because of external factors relative to information gathering or risk assessment yet the patient clearly is at risk for harm to self or others.

Treatment must be provided by a licensed physician or other licensed behavioral health professional and received in a facility accredited by COA, AOA, CARF, or The Joint Commission.

Coverage for behavioral health services is limited to the most appropriate method and level of treatment that is medically necessary.

NOTE**:** This Plan is intended to comply with the Mental Health Parity and Addiction Equity Act of 2008.

5. CHEMOTHERAPY AND RADIATION THERAPY

The Plan covers Food and Drug Administration (FDA) approved drugs used in antineoplastic therapy (chemotherapy) and the reasonable cost of the administration of the drug. These services may be covered regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug has received approval by the FDA only if all the following are true:

- The drug is ordered by or under the direction of a physician for the treatment of a specific type of neoplasm; and
- The drug is approved by the FDA for use in antineoplastic therapy; and
- The drug is used as part of an antineoplastic drug regimen; and
- Current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment; and
- The physician has obtained informed consent from the patient for the treatment regimen, which includes FDA approved drugs for off-label indications.

6. CLINICAL TRIALS

If you are a participant in an approved clinical trial, the Plan will cover routine care costs for services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in an approved clinical trial or is receiving standard therapy.

An approved clinical trial includes 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 is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

7. COMPRESSION STOCKINGS

Compression stockings must be prescribed for vascular conditions.

8. CONVENIENCE CARE FACILITY VISIT (such as UM Health-Sparrow Walk-In Care)

Care provided outside the emergency department, urgent care center or physician's office for basic medical services and common, non-life-threatening conditions. Treatment and services include but are not limited to allergies, athlete's foot, cold and flu symptoms, poison ivy and sun burn.

9. DENTAL SERVICES

ACCIDENTAL DENTAL SERVICES are covered when all the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D."
- The dental damage is severe enough that initial contact with a physician or dentist occurred within 72 hours of the accident.

Benefits are available only for treatment of a sound, natural tooth. The physician or dentist must certify that the injured tooth was:

- A virgin or unrestored tooth, or
- A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.

In no event are benefits available for the replacement of a missing tooth (dental implants), even if required as a result of an Injury.

Dental services for final treatment to repair the damage must meet both of the following:

- Started within three months of the accident.
- Completed within 12 months of the accident.

Please note that dental damage that occurs as a result of normal activities of daily living (including biting or chewing) or extraordinary use of the teeth is not considered an "accident." Benefits are not available for repairs to teeth that are injured as a result of such activities.

Pre-authorization is required for coverage of follow-up services related to the accidental injury.

OTHER MEDICAL SERVICES OF THE MOUTH are covered when provided by a physician or dentist and include:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Excision of benign or malignant bony growths of the jaw and hard palate.
- External incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands, or ducts.
- Transplant preparation.
- Initiation of immunosuppressives.
- The direct treatment of acute traumatic injury, cancer, or cleft palate.
- Oral surgery when treatment is due to a non-occupational injury and if treatment begins within one year of the injury.
- Dental-related anesthesia and associated hospital facility charges provided at an in-network hospital to an eligible dependent or member when, in the opinion of the treating dentist or oral surgeon, treatment in a dental office under local anesthesia would be ineffective or compromised; and any of the following criteria apply to the eligible dependent:
  - Has a total of six or more teeth extracted in various quadrants.
  - Has an acute infection, anatomic variation, or allergy.
  - Is under the age of seven if the patient is a child and has multiple extractions or multiple restorations.
  - Has a concurrent hazardous medical condition.
  - Has extensive oral-facial and/or dental trauma.

Benefits under this section are provided only for the anesthesia and related hospital and facility charge. Benefits are not available for any other related dental procedure (including but not limited to extractions).

Dental x-rays will not be included under x-ray and lab expenses unless given in connection with oral surgery for which surgical benefits are payable under this Plan. For covered dental x-rays the term “physician” includes a duly licensed dentist.

Benefits are not available for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease, preparing the mouth for the fitting of or continued use of dentures or removal of unerupted impacted or partially impacted wisdom tooth.

10. DIAGNOSTIC X-RAY AND LABORATORY

The Plan covers medically necessary lab and radiology/X-ray services including ultrasounds, advanced diagnostic imaging/high tech radiology such as CT scans, PET scans, MRIs, MRAs or nuclear medicine. Benefits include the facility charge, the charge for required services, supplies, and equipment.

Dental x-rays will not be included under x-ray and lab expenses unless given in connection with oral surgery for which surgical benefits are payable under this Plan. For covered dental x-rays the term “physician” includes a duly licensed dentist.

11. DURABLE MEDICAL EQUIPMENT

The Plan covers durable medical equipment when pre-authorization has been received, if required, and that meets each of the following criteria:

- Ordered or provided by a physician for outpatient use; and
- Used for medical purposes; and
- Not consumable or disposable; and
- Of use to a person only in the presence of a disease or physical disability.

University of Michigan Health Service Company on behalf of the Plan Administrator will determine if rental, purchase, repair, or replacement of the durable medical equipment is medically necessary and covered.

If more than one piece of durable medical equipment can meet your functional needs, the Plan will only cover the equipment that meets the minimum specifications for your needs. If you choose to rent or purchase durable medical equipment that exceeds these minimum specifications, the Plan will cover only the amount that would have been paid for the minimum specifications, and you will be responsible for paying any difference in cost.

Examples of durable medical equipment include:

- Oxygen and related supplies.
- Surgical brassieres following mastectomy.
- Compression stockings or sleeves prescribed for a vascular condition.
- Wig or hairpiece following chemotherapy or radiation treatment.
- Equipment to assist mobility, such as a standard wheelchair.
- Standard hospital-type bed.

- Delivery pumps for tube feedings (including tubing and connectors).
- Bi-pap and C-pap machines (including tubing, connectors, and masks).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize a body part affected by injury or illness or congenital anomaly are considered durable medical equipment and are covered by the Plan. Dental braces are excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items, which are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies.

The Plan covers a single purchase of a type of durable medical equipment once every three years. The Plan does not cover duplicate durable medical equipment items. The Plan covers repair or replacement only when necessitated due to a change in the covered person's medical condition, a change in body size due to growth, to improve physical function, or when normal wear and tear necessitates replacement.

Benefits will never be available for some items and types of durable medical equipment. Refer to the chapter MEDICAL EXCLUSIONS AND LIMITATIONS for a complete list of items that are not covered.

12. EMERGENCY DEPARTMENT VISITS (for outpatient treatment of an illness or accident)

The Plan covers services that are required to stabilize or initiate treatment in an emergency. Emergency health services described here must be received on an outpatient basis at a hospital or alternate facility.

Emergency department services for the treatment of an accident or emergent illness will always be payable at the in-network benefit rate.

Emergent illness is defined as severe symptoms occurring suddenly and unexpectedly, which could reasonably be expected to result in serious physical impairment or loss of life or could seriously jeopardize a covered person's health if not treated immediately.

If an emergency department visit results in an inpatient hospital stay, authorization is required for coverage of the inpatient stay.

13. GENDER REASSIGNMENT TREATMENT

The Plan covers gender reassignment treatment when determined to be medically necessary and have been pre-authorized.

Covered Service include but are not limited to reconstructive surgery, hormone therapy, and mental health services.

14. GENETIC TESTING

The Plan covers medically necessary genetic testing that is not unproven, experimental or investigational as determined by this Plan. Pre-authorization is required for coverage of genetic tests.

15. HEALTH EDUCATION COUNSELING (in-network only)

The Plan covers health education counseling such as diabetes self-management training when related to a medical condition, recommended by your physician, and provided by an in-network licensed medical professional or at an in-network outpatient training program that is certified to receive Medicaid or Medicare reimbursement or certified by the Michigan Department of Community Health.

Charges for food or food replacements, formula and nutritional or electrolyte supplements are not covered.

- Health Education Counseling:

- Must be provided by a qualified health care professional.
- Conditions for which Health Education Counseling is a Covered Health Service include, but are not limited to:
  - Weight management.
  - Diabetes mellitus.
  - Coronary artery disease.
  - Congestive heart failure.
  - Severe obstructive airway disease.
  - Gout.
  - Renal Failure.
  - Phenylketonuria.
  - Hyperlipidemias.

16. HEMODIALYSIS

17. HOME HEALTH CARE

Covered charges include home health care services that are pre-authorized and provided by or supervised by a registered nurse. The attending physician must prescribe these services instead of a hospital confinement and pre-authorization is required.

Benefits are available only when the home health agency services are provided on a part-time, intermittent schedule and when skilled care is required. A service will not be determined to be “skilled” simply because there is not an available Team Member.

Skilled care is skilled nursing, skilled teaching, skilled rehabilitation, and home infusion services when all the following are true:

- It must be delivered or supervised by a licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient; and
- It is ordered by a physician; and
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair; and

- It requires clinical training in order to be delivered safely and effectively; and
- It is not custodial care.

Benefits for outpatient rehabilitation services provided in your home are described under REHABILITATION THERAPY SERVICES later in this chapter.

18. HOME INFUSION THERAPY

The Plan covers home infusion therapy services that have been pre-authorized and are all the following:

- Provided to treat an acute condition; or
- Provided to manage an incurable or chronic condition; and
- Provided to treat a condition that requires acute care if it can be managed safely at home; and
- Medically necessary as determined by University of Michigan Health Service Company medical policy and nationally recognized guidelines; and
- Ordered by a physician; and
- Provided by or supervised by a registered nurse on an intermittent basis in the home.

Benefits are available when provided by a home infusion therapy provider for medical IV therapy, injectable therapy, or total parenteral nutrition therapy; including nursing services, supplies, prescription drugs and solutions, and family education.

The Plan covers nursing visits needed to:

- Administer home infusion therapy or parenteral nutrition.
- Instruct patient or Team Members on infusion administration techniques.
- Provide IV access care (catheter care).

When appropriate, patient will learn to administer home infusion therapy medications.

Benefits for home health care services provided in conjunction with home infusion therapy are described above under HOME HEALTH CARE.

19. HOSPICE CARE

Covered charges include charges made by a hospice or other facility by or on behalf of a hospice. Charges must be incurred during a Hospice Benefit Period and pre-authorization is required for coverage.

Covered hospice charges include: inpatient hospice care (that is not considered custodial care), including physician's services; home health services, including services furnished by qualified aides under the supervision of an RN, and medical appliances and supplies, including drugs and biologicals used for the relief of pain and symptom control; counseling services; homemaker services to enable the individual to carry out the treatment plan; social services provided by a social worker under the direction of a physician; bereavement counseling during the period the Plan remains in effect; local ambulance or special transport between the home and hospice facility.

20. INFERTILITY TREATMENT

Services for the diagnosis and treatment of infertility include medically necessary treatment and procedures that treat the underlying medical conditions that result in infertility (e.g., endometriosis, blockage of fallopian tubes, varicocele, etc.).

Not all services connected with the treatment of infertility are covered health services. Services and treatment, including medications, to conceive a pregnancy are not covered.

21. INJECTIONS AND INFUSIONS RECEIVED IN A PHYSICIAN'S OFFICE

The Plan covers medically necessary injections and infusions (including allergy injections) received in a physician's office.

The Plan covers pre-authorized drugs and medications for which criteria must be met for coverage. The list includes but is not limited to specialty prescription drug products that must typically be administered or supervised by a qualified health care providers or licensed/certified health care professional in an outpatient setting. We determine which specific drugs are Covered Health Services and this list is subject to change. The list may include vaccines and chemotherapy drugs used in the treatment of cancer but excludes injectable insulin, which does not require pre-authorization. Please contact Customer Service for current information.

The list of these drugs and medications is subject to change following review by the University of Michigan Health-Sparrow (UMH-S) Collaborative Pharmacy and Therapeutics (P&T) Committee (made up of the Committees of SPN, University of Michigan Health-Sparrow Hospital and University of Michigan Health Service Company). Contact Customer Service for current information.

22. INPATIENT HOSPITAL SERVICES (other than behavioral health)

Inpatient hospital expenses include:

- Ward or semi-private room and board in a hospital, sub-acute facility, or physical rehabilitation facility.
- Charges for hospital services.
- Charges for hospital special units (intensive care [ICU], cardiac care [CCU], burn).

You will pay the daily difference between the private and semi-private rate. Expenses for a private room will be covered if verified by the attending physician as medically necessary.

Inpatient hospital stays must be authorized by University of Michigan Health Service Company.

Personal items - (e.g., telephone and television) are not covered.

NOTE**:** If a hospital confinement extends from one calendar year to the next, the Plan will pay the benefit as if the entire hospital confinement took place in the year the admission commenced.

23. MEDICAL SUPPLIES

The Plan covers medical supplies such as splints, crutches, trusses, walkers, and diabetic supplies ordered by a legally qualified physician for treatment of an injury or illness.

24. NUTRITIONAL EDUCATION COUNSELING (in-network only)

Nutritional education counseling teaches the scientific knowledge behind the nutritional function of foods as well as the daily nutritional requirements for optimal health. Nutritional counseling may include education in nutritional facts, eating habits, nutrients, and allergies related to food. The Plan covers nutritional education counseling services during a Routine Preventive Health Service visit.

Charges for food or food replacements, formula and nutritional or electrolyte supplements are not covered.

25. OSTOMY SUPPLIES

Benefits for ostomy supplies required as a result of a colostomy or ileostomy include only the following:

- Pouches, face plates, and belts.
- Irrigation sleeves, bags, and catheters.
- Skin barriers.

Benefits are not available for gauze, filters, lubricants, tape, appliance cleaners, adhesive, adhesive removers, deodorant, pouch covers, or other items not listed above.

26. PHYSICIAN'S OFFICE VISITS (for treatment of illness or accident by PCP or specialist)

Physician's office visits are covered regardless of whether the physician's office is free-standing, located in a clinic or located in a hospital.

Covered Persons may be directed to the site of care for administration of specific medications that is most cost-effective, clinically appropriate, and/or can be safely administered such as a Physician's office or through home infusion services.

NOTE: Some Physician offices are Hospital-owned and considered outpatient Hospital locations. Covered Health Services may apply to your Annual Deductible and Coinsurance instead of or in addition to a Physician office visit Copayment. For clarification of the Physician's billing practices, please contact the provider.

Podiatric Services – charges for open cutting operations, the removal of nail roots and necessary services in the treatment of metabolic or peripheral vascular services are covered. Charges for shoe orthotics, orthopedic shoes and diabetic shoes are covered (see SHOE ORTHOTICS, ORTHOPEDIC SHOES AND DIABETIC SHOES AND INSERTS). Routine foot care, or foot care only to improve comfort or appearance is not covered.

27. PREGNANCY SERVICES (pre-, postnatal and delivery charges)

NOTE**:** in no event shall the length of the inpatient hospital stay for childbirth (for either the mother or the newborn) be restricted to less than the federally-mandated 48 hours following a vaginal birth or 96 hours following a cesarean section. However, Federal law 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 may not, under Federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours or 96 hours. Inpatient stays over the federal minimums must be authorized for coverage.

NOTE**:** This Plan is intended to comply with the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA).

This benefit will be extended to all females covered on the Plan. Pregnancy charges include mother's hospital expenses, delivery, and pre- and postnatal care expenses. The newborn's hospital and physician expenses will also be covered. If a dependent child becomes pregnant, benefits will extend to the mother only. For coverage to extend to the newborn (grandchild), the Team Member must assume legal guardianship of the newborn.

NOTE**:** The newborn child must be enrolled within 30 days of birth to be eligible for benefits from the date of birth.

Birthing centers are not covered.

Outpatient uterine monitoring will be covered only if medically necessary.

28. PREGNANCY TERMINATION

The Plan covers one procedure for termination of pregnancy per lifetime per covered person.

29. PRESCRIPTION DRUGS - OUTPATIENT

Prescription drugs are subject to the exclusions and limitations described herein including, but not limited to, the Plan Administrator's determination that: the prescription is medically necessary; that charges are Reasonable and Customary; that prescriptions are not experimental and/or investigational, and that the prescription drugs are prescribed by a physician. The meanings of these capitalized terms are in the chapter, DEFINITIONS FOR THE PURPOSE OF THE PLAN.

Prescription drugs under the Plan may be purchased at UMH-S owned pharmacies or at any nationwide pharmacy participating with Express Scripts.

The Coordination of Benefits provision does not apply to outpatient Prescription Drug Products managed by the Pharmacy Benefit Manager. Prescription Drug Product Benefits will not be coordinated with those of any other health coverage plan nor will co-pays be reimbursed under this Plan.

Prescription drugs purchased at any location other than UMH-S or Express Scripts pharmacies will not be reimbursed by this Plan unless the prescription is required on an urgent or emergency basis and the drug could not have been purchased from one of the UMH-S or Express Scripts pharmacies. If you require prescription drugs on an urgent or emergency basis, you must pay for the prescription drug and submit your receipt to University of Michigan Health Service Company for possible reimbursement. You must submit proof that substantiates the prescription drug was needed on an urgent or emergency basis, and that the drug could not have been purchased from one of the UMH-S or Express Scripts pharmacies.

The maximum amount or quantity of prescription drugs covered per co-pay is a 34-day supply, unless adjusted based on the drug manufacturer's packaging size, or based on supply limit. The maximum amount or quantity of prescription drugs in a 35-day supply up to a 90-day supply is available for two co-pays, unless adjusted based on the drug manufacturer's packaging size, or based on supply limit, at all UMH-S and Express Scripts retail pharmacies or through Express Scripts mail-order service.

Specialty Drugs when obtained as outpatient prescription drugs are only available in up to a 31-day supply with one co-pay from either a UM Health-Sparrow Specialty Pharmacy. Medications on the UM Health-Sparrow Medication Extended Supply List are available for one co-pay (up to a 90-day supply), regardless of unit dosage.

Covered Persons may be directed to the site of care for administration of specific medications that is most cost-effective, clinically appropriate, and/or can be safely administered such as a Physician's office or through home infusion services.

If a Brand-Name Drug Becomes Available as a Generic.

If a Generic Prescription Drug Product becomes available for a Brand-Name Prescription Drug Product, the tier placement of the Brand-Name Prescription Drug Product may change, and therefore your Copayment or Coinsurance amount may change. You pay the Copayment or Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.

Brand Generic Difference.

If you or your health care provider elect a Brand Name Drug when there is a Generic Drug available that is chemically the same, you must pay the Brand Generic Difference, which is the cost difference between the two drugs in addition to your applicable Copayment or Coinsurance amount. The Brand Generic Difference and charges above Eligible Expenses do not apply to your Annual Out of Pocket Maximum.

During the contract term, the formulary for generic, preferred, and non-preferred drugs may be modified by the UMH-S Collaborative P&T Committee. A MNA representative with technical knowledge regarding prescriptions is included on the Committee. The formulary is available on the UMH-S Intranet web site.

During the contract term, the formulary for generic, preferred, and non-preferred drugs may be modified by the UMH-S Collaborative P&T Committee. A UAW representative with technical knowledge regarding prescriptions is included on the Committee. The formulary is available on the UMH-S Intranet web site.

Certain preventive drugs as mandated by the ACA are covered at 100% when obtained at UMH-S and Express Scripts pharmacies:

- A select group of contraceptive medications for women. This list includes at least one product in each of the 18 FDA-approved contraceptive methods.
- A select group of bowel prep medications for adults ages 45 through 74. Two prescriptions are covered in 365 days.
- Aspirin to prevent cardiovascular disease and colorectal cancer for adults ages 50 through 59 and aspirin to prevent morbidity and mortality from pre-eclampsia in women ages 12 through 55; fluoride for children from birth to five years of age; folic acid for women of childbearing years through age 50; and low-dose statins for adults ages 40 to 70.
- A select group of Preferred Tobacco Cessation Products. Preferred Tobacco Cessation Products must be prescribed by a Physician (even if the product is available as an over-the-counter product) and can only be obtained from a retail network pharmacy in up to a 34-day supply. The member must be an adult age 18 or older.

- Tamoxifen or Raloxifene for risk reduction of primary breast cancer for women 35 years of age or older who meet criteria.
- Preferred glucose monitors, syringes, test strips, lancets, and alcohol swabs are covered at no cost share.

Note: Non-preferred glucose monitors, syringes, test strips, lancets, and alcohol swabs are covered with applicable copay; deductible does not apply.

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The list of these medications is subject to change. Call Customer Service for more information or contact any Pharmacy Plus location for a list of these preventive medications.

Other requirements, exclusions and limitations may apply as provided elsewhere in the Detailed Benefit Booklet, which is available on the UMH-S Intranet web site.

NOTE on Authorization Requirements: If authorization for a particular Prescription Drug Product is required and is not obtained from University of Michigan Health Service Company by your provider before the Prescription Drug Product is dispensed, you can ask us 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 University of Michigan Health Service Company as described in the chapter, CLAIM FILING PROCEDURE.

When you submit a claim on this basis, you may pay more because you did not obtain authorization from the Claims Administrator before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required co-pay or coinsurance amount.

Vacation Override

Caregivers may request to refill their prescriptions early due to being out of the area when prescriptions are scheduled to be filled. Requests for vacation overrides may be approved up to two times per calendar year for a one-month supply based on the following procedure:

- Pharmacy/Member contacts University of Michigan Health at 517.364.8545 with the subscriber name, subscriber number, and name of the medication.
- The Pharmacy Department clinically reviews and assesses the vacation override request on a case-by-case basis.
- Requests for any of the following must be approved by Human Resources (HR):
    a. More than a month's supply of medication is requested.
    b. The request is for a controlled substance/narcotic
    c. More than two vacation overrides have been requested in the same year

The Pharmacy Department clinically reviews the request, and if approved, we request the final approval from Total Rewards Caregiver in HR. Applicable copays will apply.

30. PREVENTIVE HEALTH SERVICES (in-network only)

The complete list of recommendations and guidelines can be found at http://www.HealthCare.gov/center/regulations/prevention.html (the “List”) and is continually updated to reflect both new recommendations and guidelines and revised or removed guidelines.

The Plan covers preventive health services when provided by a network provider including, but not limited to, the following:

Covered Preventive Health Services for Adults

- Annual routine physical exams
- Screenings such as:
  - Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
  - Alcohol Misuse screening
  - Blood Pressure screening for all adults
  - Cholesterol screening for adults of certain ages or at higher risk
  - Colorectal Cancer screening for adults over 45, including a select group of Prescription Drug Products for bowel prep (for adults ages 45 through 74 – two prescriptions are covered in 365 days)
  - Depression screening for adults
  - Type 2 Diabetes screening for adults with high blood pressure
  - Hepatitis B screening for people at higher risk
  - Hepatitis C screening for people at higher risk
  - HIV screening for all adults at higher risk
  - Obesity screening for all adults
  - Tobacco Use screening for all adults
  - Syphilis screening for all adults at higher risk
  - Tuberculosis screening for certain adults at higher risk
- Counseling such as:
  - Aspirin use for men and women of certain ages
  - Alcohol Misuse counseling
  - Nutritional counseling for adults at higher risk for chronic disease (considered to be Preventive Health Services)
  - Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
  - Nutritional counseling for all adults in relation to obesity (considered to be Preventive Health Services)
- Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:

- Hepatitis A
- Hepatitis B
- Herpes Zoster
- Human Papillomavirus
- Influenza
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Tetanus, Diphtheria, Pertussis
- Varicella

- Other services such as cessation interventions for tobacco users

Covered Preventive Health Services for Women, Including Pregnant Women

- Annual routine physical exams
- Annual well-woman visits
- HPV DNA testing for women 30 years and older
- Screenings such as:
  - Gestational diabetes for pregnant women
  - HIV screening
  - Interpersonal and domestic violence screening
  - Anemia screening on a routine basis for pregnant women
  - Bacteriuria urinary tract or other infection screening for pregnant women
  - Breast cancer mammography screenings (one screening per calendar year regardless of age)
  - Cervical cancer screening for sexually active women
  - Chlamydia Infection screening for younger women and other women at higher risk
  - Gonorrhea screening for pregnant women and all women at higher risk
  - Hepatitis B screening for pregnant women at their first prenatal visit
  - Osteoporosis screening for women over age 60 depending on risk factors
  - Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
  - Tobacco use screening for all women, and expanded counseling for pregnant tobacco users
  - Syphilis screening for all pregnant women or other women at increased risk
  - Urinary incontinence screening

- Counseling such as:
  - Sexually-transmitted infection counseling
  - HIV counseling
  - Contraceptive counseling
  - Breast feeding support and counseling
  - Interpersonal and domestic violence counseling
  - BRCA genetic counseling for women at higher risk
  - Breast cancer chemoprevention counseling for women at higher risk
  - Use of Folic Acid supplements for women who may become pregnant
- Other services such as:
  - Tobacco use interventions for all women
  - Breast feeding interventions to support and promote breast feeding, including breast pumps supplied by our designated vendor
  - Select FDA-approved contraceptive methods on the Contraceptive Prescription Drug List
  - Tamoxifen or Raloxifene for risk reduction of primary breast cancer for women age 35 years of age or older who meet criteria

Covered Preventive Health Services for Children

- Annual routine physical exams including well baby and well child visits
- Screenings such as:
  - Autism screening for children at 18 and 24 months
  - Blood screening for newborns
  - Cervical Dysplasia screening for sexually active females
  - Congenital Hypothyroidism screening for newborns
  - Depression screening for adolescents beginning routinely at age 12
  - Developmental screening for children under age three, and surveillance throughout childhood
  - Dyslipidemia screening for children at higher risk of lipid disorders
  - Hearing screening for all newborns
  - Hematocrit or Hemoglobin screening for children
  - Hemoglobinopathies or sickle cell screening for newborns
  - Hypothyroidism screening for newborns
  - HIV screening for adolescents at higher risk
  - Lead screening for children at risk of exposure
  - Obesity screening

    - Phenylketonuria (PKU) screening for this genetic disorder in newborns
    - Vision screening for all children
- Assessments such as:
    - Alcohol and Drug Use assessments for adolescents
    - Behavioral assessments for children of all ages
    - Height, Weight and Body Mass Index measurements for children
    - Medical History for all children throughout development
    - Oral Health risk assessment for young children
- Counseling such as:
    - Use of Fluoride Chemoprevention supplements for children without fluoride in their water source
    - Nutritional counseling (considered to be Preventive Health Services)
    - Sexually Transmitted Infection (STI) prevention counseling for adolescents at higher risk
- Immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary):
    - Diphtheria, Tetanus, Pertussis
    - Haemophilus influenzae type b
    - Hepatitis A
    - Hepatitis B
    - Human Papillomavirus
    - Inactivated Poliovirus
    - Influenza
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Rotavirus
    - Varicella
    - Other services such as:
    - Tuberculin testing for children at higher risk of tuberculosis
    - Gonorrhea preventive medication for the eyes of all newborns

NOTE: This benefit is subject to change in compliance with The Affordable Care Act.

31. PROFESSIONAL FEES FOR SURGICAL AND MEDICAL SERVICES

The plan covers professional fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a hospital, skilled nursing facility, inpatient

rehabilitation facility or alternate facility, or for physician house calls. When these services are performed in a Physician's office, Benefits are described under PHYSICIAN'S OFFICE SERVICES above. Services include those of surgeon, assistant surgeon, anesthesiologist, inpatient attending physician and inpatient physician consultant.

When two or more surgical procedures are performed at the same time, but in different operative fields and due to different causes, payment will be made for each operation. When two or more surgical procedures are performed at the same time and in the same operative field, the full reasonable and customary charge will be paid for the primary surgical procedure and one-half of the reasonable and customary charge will be paid for the secondary surgical procedure.

32. PROSTHETIC APPLIANCES (functional or non-functional)

FUNCTIONAL: (limbs, braces, orthotics, or prosthetic devices), but not including expenses for replacement, or repair and maintenance unless occasioned by natural childhood growth, a change in patient's medical condition, pathological changes or to improve physical function. Required training resulting from a replacement of a limb or organ shall be covered.

NON-FUNCTIONAL: (artificial eyes, ears, larynx), but not including replacement, repair or maintenance unless occasioned by natural childhood growth, a change in patient's medical condition, pathological changes or to improve physical function. Required training resulting from the replacement of a limb or organ will be covered.

If more than functional or non-functional prosthetic appliance meets your needs, the Plan will only cover the appliance that meets the minimum specifications of your needs. If a covered person chooses to purchase a prosthetic appliance that exceeds these minimum specifications, the Plan will cover only the amount that would have been paid for the minimum specifications, and you will be responsible for paying any difference in cost.

Pre-authorization is required if the prosthetic device costs more than $1,000.000. The prosthetic device must be medically necessary, as determined by this Plan and ordered or provided by, or under the direction of a physician. Benefits are not provided for duplicates.

33. RECONSTRUCTIVE PROCEDURES

The Plan covers medically necessary services for reconstructive procedures that have been pre-authorized when a physical impairment exists, and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures, which are associated with an injury, illness or congenital anomaly.

The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a cosmetic procedure when a physical impairment exists, and the surgery restores or improves function.

Except as noted below, cosmetic procedures are excluded from coverage. Procedures that correct an anatomical congenital anomaly without improving or restoring physiologic function are considered cosmetic procedures. The fact that a covered person may suffer psychological consequences or socially avoidant behavior as a result of an injury, illness or congenital anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.

Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), including treatment of complications, are provided in the same manner and at the same level as those for any other covered health service.

Cosmetic surgery will be covered:

- When due to a congenital anomaly that has been determined by the attending physician as requiring medically necessary treatment; or
- For eligible dependent children to the end of the calendar year they turn age 19, when due to an accidental injury or traumatic scar; or
- For eligible dependent children over the age of 19, a Team Member or the eligible dependent spouse of a Team Member, when due to a non-occupational injury or traumatic scar if treatment begins within one year of the injury (unless postponement is certified by the attending physician as medically necessary).

34. REHABILITATION THERAPY SERVICES

The following covered outpatient rehabilitation therapy services must be performed by a licensed therapy provider, under the direction of a physician. Benefits are available only for rehabilitation services that are expected to result in significant improvement in your condition within two months of the start of treatment.

- PHYSICAL THERAPY to aid in the recovery of bodily function after injury or disease excluding learning disabilities and developmental delays (except for covered services for Autism Spectrum Disorders).
- OCCUPATIONAL THERAPY for treatment of injury or illness excluding learning disabilities and developmental delays (except for covered services for Autism Spectrum Disorders).
- SPEECH THERAPY by a certified speech therapist to correct an impairment (except voice modulation or lisp) due to a congenital defect for which corrective surgery has been performed, or to correct an impairment caused by an injury or illness except a mental illness, psychoneurotic or personality disorders, learning disabilities, or developmental delays (except for covered services for Autism Spectrum Disorders).
- CARDIAC REHABILITATION (PHASE II ONLY) Services must be medically necessary; rendered under the supervision of a physician; in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; or other medical conditions if medically appropriate and initiated within 12 weeks after other treatment for the medical condition ends.
- PULMONARY REHABILITATION (PHASE II ONLY) Services must be medically necessary and rendered under the supervision of a physician.

Speech therapy received on an outpatient basis require prior authorization for coverage.

35. SHOE ORTHOTICS/ORTHOPEDIC SHOES/DIABETIC SHOES AND INSERTS

Orthopedic shoes, diabetic shoes, diabetic shoe inserts, and shoe orthotics must be prescribed by a physician.

Repairs or replacements are covered if ordered by a physician or practitioner qualified to prescribe the device and due to natural childhood growth or pathological change.

36. SKILLED NURSING FACILITY AND INPATIENT REHABILITATION FACILITY

Covered charges include the daily semi-private room and board charge for each day of confinement, and the facility's other charges incurred for medical care on a day for which room and board benefits are payable.

Benefits are available only when skilled care is required. A service will not be determined to be "skilled" simply because there is not an available Team Member.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all the following are true:

- It has been pre-authorized.
- It must be delivered or supervised by a licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient; and
- It is ordered by a physician; and
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing, or transferring from a bed to a chair; and
- It requires clinical training in order to be delivered safely and effectively; and
- It is not custodial care.

Please note that benefits are available only if both of the following are true:

- If the initial confinement in a skilled nursing facility or inpatient rehabilitation facility was or will be a cost-effective alternative to an inpatient hospital stay.
- You will receive skilled care services that are not primarily custodial care.

These services must be ordered in writing by the attending physician instead of hospital confinement. Confinement must begin after a hospital confinement for the same or a related cause and within 14 days after discharge from the hospital.

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.

Skilled nursing facilities/inpatient rehabilitation facilities must be pre-authorized for coverage.

37. SPINAL TREATMENT SERVICES (including x-rays)

- The Plan covers:
- Chiropractic or osteopathic manipulation treatment when provided by a Spinal Treatment provider (Chiropractor or Doctor of Osteopathy, "D.O.")
- Services and supplies for analysis and adjustment of spinal subluxation(s) and spinal misalignment(s).
- Diagnosis and treatment by manipulation of the skeletal structure.

- Muscle stimulation by any means (except treatment of fractures and dislocations of the extremities).
- Rehabilitative exercise related to spinal subluxation(s) or spinal misalignment(s)
- X-rays of the spine.

38. SURGICAL BRASSIERES (following mastectomy)

39. SURGICAL STERILIZATION – FEMALE AND MALE

34. TELEMEDICINE SERVICES

Telemedicine services for certain medically necessary health services are provided under this Plan.

“Telemedicine” means the use of an electronic medium to link patients with healthcare professionals in different locations. The healthcare professionals would have to be able to examine the patient via a real-time, interactive audio and/or video telecommunications system and the patient must be able to interact with the offsite professional at the time the services are provided. Telemedicine services must be provided by healthcare professionals who are licensed, registered, or otherwise authorized to engage in his/her healthcare profession in the state where the patient is located.

Not all eligible health services are covered telemedically such as, but not limited to, new patient examinations, preventive health services and surgery.

41. TOBACCO CESSATION PROGRAM

A Tobacco Cessation Program is offered to plan participants that includes participation in a select credentialed counseling program and coverage for Preferred Tobacco Cessation Products available under your outpatient prescription drug plan.

Preferred Tobacco Cessation Products must be prescribed by a physician and obtained from a network retail pharmacy, even if the product is available as an over-the-counter product.

Preferred Tobacco Cessation Products are covered under your Prescription Drug Plan at 100%. Please call any UMH-S Pharmacy location for a list of these medications.

Call Customer Service for complete details on the counseling program and the current list of Preferred Tobacco Cessation Products.

42. TRANSPLANTATION SERVICES

University of Michigan Health Service Company must be notified as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). Pre-authorization is required for coverage.

Transplantation programs typically include three phases: pre-transplant services, the transplant period and post-transplant services. Under the Plan’s transplantation services benefit, each phase must be reviewed separately for authorization. Transplant services not covered under the transplant contract and/or not provided at the Designated Facility will be covered under other sections of this Plan.

Medically necessary services for the following organ and tissue transplants when ordered by an in-network physician and received at a Designated Facility. Benefits are available for the transplants listed below when the transplant has been pre-authorized and is not an experimental, investigational, or unproven service:

- Hematopoietic stem cell transplants (either from Plan participant or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all hematopoietic stem cell transplants are covered.
- Heart transplants.
- Heart/lung transplants.
- Lung transplants.
- Kidney transplants.
- Kidney/pancreas transplants.
- Liver transplants.
- Liver/small bowel transplants.
- Pancreas transplants.
- Small bowel transplants.
- CAR-T cell immunotherapy.

Donor expenses for a donor who is not an eligible covered participant of this Plan are covered if not covered by the donor's plan. If the donor is covered under this Plan, eligible medical expenses incurred by the donor will be eligible for benefit coverage.

The cost of securing an organ or tissue from a cadaver or tissue bank, including the surgeon's charge for removal of the organ or tissue and a hospital's charge for storage or transportation of the organ or tissue, will be considered a covered expense.

Donor search charges will be covered.

This Plan has specific guidelines regarding benefits for transplant services. Contact Customer Service for information about these guidelines.

43. URGENT CARE FACILITY VISIT

Services received at an urgent care facility. Covered services at out-of-network urgent care facilities are covered at the in-network benefit rate for non-UMH-S-owned in-network facilities.

When services to treat urgent health care needs are provided in a physician's office, benefits are available as described under PHYSICIAN'S OFFICE SERVICES earlier in this chapter.

44. WEIGHT MANAGEMENT SERVICES

Benefits include physician office visits, outpatient behavioral health therapy visits, nutritional counseling (limits apply), outpatient laboratory and pathology services and qualified weight management programs.

The Plan does not cover:

- Weight management services received from out-of-network health care providers.
- Nutritional supplies, body fat testing, or educational materials that are not included in the qualified weight management program fees.

45. WIG OR HAIRPIECE FOLLOWING CHEMOTHERAPY OR RADIATION TREATMENT

MEDICAL EXCLUSIONS AND LIMITATIONS

HOW TO USE HEADINGS IN THIS CHAPTER

To help you find specific exclusions more easily, headings are used to group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath these headings. A heading does not create, define, modify, limit or expand an exclusion or a limitation.

THE PLAN DOES NOT PAY BENEFITS FOR EXCLUSIONS

The Plan does not provide benefits for any of the services, treatments, items or supplies described in this chapter, even if either of the following is true:

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

A. ALTERNATIVE TESTING AND TREATMENT

Charges for alternative testing and treatment as defined by the National Center for Complementary and Alternative Medicine.

B. BEHAVIORAL HEALTH

- Charges for services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- Charges for behavioral health services as treatment for neurological disorders and other disorders with a known physical basis when such conditions are solely medical in nature and that may be covered under other benefit categories of this Plan.
- Charges for treatment for conduct and impulse control disorders, personality disorders, and paraphilias.
- Charges for treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized.
- Charges for services provided outside of an inpatient, intermediate, or outpatient setting.
- Charges for behavioral health services for the following:
  - Sleep disorders.
  - Delirium, dementia, and amnesic and other cognitive disorders.
  - Therapy for pervasive developmental disorders, except for treatment of certain Autism Spectrum Disorders.
  - Psychotherapy for feeding, tic, and elimination disorders.
  - Marital counseling.
  - Transitional living centers, wrap-around care services, halfway or three-quarter-way houses, non-licensed programs, therapeutic boarding schools, or milieu therapies.
  - Sex therapy.

- Charges for services or supplies for the diagnosis or treatment of mental illness, alcoholism or substance use disorders that are any of the following:
  - Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
  - Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
  - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
  - Not consistent with care guidelines or best practices as modified from time to time.

NOTE**:** We may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

C. COMFORT OR CONVENIENCE

- Charges for television.
- Charges for telephone.
- Charges for beauty/barber service.
- Charges for guest service.
- Charges for supplies, equipment and similar incidental services and supplies for personal comfort, or for the convenience of either the covered person or his or her physician.

D. DENTAL AND RELATED ORAL/MOUTH CONDITIONS

- Charges for dental services except as outlined in the Plan.
- Charges for preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all the following:
  - Extraction, restoration, and replacement of teeth (including extraction of impacted wisdom teeth).
  - Medically necessary medical or surgical treatments of dental conditions.
  - Services to improve dental clinical outcomes.
- Charges for tooth implants and related services, bone grafts and other implant-related procedures and related services, even when required as a result of an injury.
- Charges for orthodontic services, including braces.
- Charges for dental X-rays, all hospitalization charges, facility charges, and anesthesia charges related to dental care. The only exceptions to this are for any of the following:
  - Transplant preparation.
  - Initiation of immunosuppressives.
  - The direct treatment of acute traumatic injury, cancer, or cleft palate.

  - Dental-related anesthesia and associated hospital facility charges provided as described in the Schedule of Benefits.

- Charges for supplies and appliances and all associated expenses (including occlusal splints, dental prosthetics, and dental orthotics). Mouth rehabilitation. Bridges. Partial plates. Dentures.
- Charges for treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.
- Charges for the evaluation and treatment of Temporomandibular Joint Syndrome (TMJ) when it is not medically necessary as determined by the Claims Administrator.

E. DRUGS AND MEDICATIONS

- Charges for non-legend vitamins, hair growth stimulants or any drug prescribed to achieve or alleviate a cosmetic condition.
- Charges for drugs not specifically included in the definition of “prescription drug.”
- Charges for any drug labeled, “Caution-limited by Federal Law to Investigational Use,” or experimental drugs even though a charge is made to the individual.
- Charges for non-legend, patent or proprietary medicine or medication not requiring a prescription, except insulin.
- Charges for prescriptions filled at an out-of-network pharmacy unless prescribed as a result of urgent or emergent care.
- Charges for self-injectable medications. This exclusion does not apply to medications, which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
- Charges for compounded medications.
- Charges for replacement for a previously dispensed prescription drug product even if lost, stolen, broken, or destroyed.
- Charges for prescription drug products, including new prescription drug products or new dosage forms that are determined to not be covered under the Plan.
- Charges for over-the-counter drugs unless stated as covered.
- Charges for fertility drugs.

F. EXPERIMENTAL, INVESTIGATIONAL OR UNPROVEN SERVICES

Charges for services, care, supplies, or devices which are experimental, investigational, unproven or research oriented in nature are excluded. The fact that an experimental, investigational, or unproven service, treatment, device, or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be experimental, investigational, or unproven in the treatment of that particular condition.

G. MEDICAL SUPPLIES AND APPLIANCES AND DURABLE MEDICAL EQUIPMENT

- Charges for devices used specifically as safety items and/or to affect performance in sports-related activities.
- Charges for cranial helmets, unless medically necessary.
- Charges for arch supports and inlays, shoes or braces whose primary purpose is to provide comfort.
- Charges for heating pads, or hot water bottles.
- Charges for prescribed or non-prescribed disposable medical supplies, including but not limited to:
  - Ace bandages.
  - Disposable dressings used for wound care.
  - Diapers.
  - Non-diabetic syringes.
- Charges for orthotic appliances that straighten or re-shape a body part, including some types of braces. Examples include cranial banding and some types of braces, including over-the-counter orthotic braces.
- Charges for shoe orthotics for the sole purpose of treating sports-related activities.
- Charges for footwear, including but not limited to, sandals and skates.
- Charges for replacement if necessitated due to misuse or loss.
- Charges for mass produced, brand name shoe orthotics or orthopedic shoes that have not been custom fitted and custom made.
- Charges for more than one shoe orthotic per foot.

H. NUTRITION OR HEALTH EDUCATIONAL COUNSELING

- Charges for megavitamin and nutrition based therapy.
- Charges for enteral feedings, food and food replacements, nutritional and electrolyte supplements, infant formula, and donor breast milk; even if any are the sole source of nutrition or as part of treatment.
- Charges for nutritional or health education counseling when not related to a medical condition or when provided out-of-network.

I. PHYSICAL APPEARANCE

- Charges for cosmetic procedures, including but not limited to:
  - Pharmacological regimens, nutritional procedures, or treatments.
  - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).

- Skin abrasion procedures and other dermatological treatment that is cosmetic in nature.
- Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple (benign gynecomastia).
- Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
- Treatment for spider veins.
- Hair removal by any means.

- Charges for the removal or replacement of an existing breast implant if it was initially performed as a cosmetic procedure, unless due to medically necessary complications. NOTE: In compliance with the Women's Health and Cancer Rights Act of 1998 (WHCRA), reconstructive surgery of a breast following a mastectomy and surgery and reconstruction of the other breast to produce a symmetrical appearance are not considered cosmetic surgery.
- Charges for cosmetic surgery except as allowed under the RECONSTRUCTIVE PROCEDURES segment of the chapter, ELIGIBLE MEDICAL EXPENSES.
- Charges for physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
- Charges for wigs or hairpieces, except following chemotherapy or radiation treatment.

J. PROVIDERS

- Charges for any services provided by a member of the covered person's immediate family, including spouse, brother, sister, parent, or child, or by a person normally living in the covered person's home. This includes any service the provider may perform on himself or herself.
- Charges for services performed by a provider with your same legal residence.
- Charges for services provided at a free-standing or hospital-based diagnostic facility without an order written by a physician or other provider. Services that are self-directed to a free- standing or hospital-based diagnostic facility. Services ordered by a physician or other provider who is an employee or representative of a free-standing or hospital-based diagnostic facility, when that physician or other provider:
  - Has not been actively involved in your medical care prior to ordering the service, or
  - Is not actively involved in your medical care after the service is received.

NOTE**:** This exclusion does not apply to mammography screening.

- Charges for foreign language and sign language interpreters.
- Telephone consultations that do not meet the criteria as described under the TELEMEDICINE SERVICES segment of the chapter, ELIGIBLE MEDICAL EXPENSES.

K. REPRODUCTION

- Charges for health services and associated expenses to conceive a pregnancy including but not limited to, artificial insemination, in vitro fertilization, gamete

intrafallopian transfer (GIFT) procedures, zygote intrafallopian transfer (ZIFT) procedures or any other treatment or procedure designed to create a pregnancy, and any related prescription medication treatment. Embryo transport. Donor ovum and semen and related costs including collection and preparation.

- Charges for outpatient uterine monitoring unless medically necessary.
- Charges for ultrasound testing for the sole purpose of determining the sex of the fetus.
- Charges for the reversal of surgical sterilization. This exclusion does not apply to covered charges resulting from complications of such a procedure.
- Charges for cryo-preservation and other forms of preservation of reproductive materials.
- Charges for long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
- Charges for donor services.

L. SERVICES PROVIDED UNDER ANOTHER PLAN

- Charges in connection with an illness or injury sustained while doing any act or thing pertaining to any occupation or employment for remuneration or profit, and for which benefits are payable in accordance with the provisions of Worker’s Compensation or any similar law.
- If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any injury or illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
- Charges incurred while you or your dependent are confined due to a service-connected illness, injury or disability in a hospital operated by the United States of America or an agency thereof, including a Veteran’s Administration Hospital, or charges which you would not be required to pay if there were no coverage. This exclusion does not apply to otherwise eligible expenses provided at a Veteran’s Administration Hospital that are non-service-connected pursuant to Section 1729 of Title 38 of the United States Code regarding Veteran’s Benefits, as amended, and any regulations promulgated thereunder.
- Charges for health services while on active military duty.
- Charges are not payable simultaneously under more than one chapter or section of this Plan.
- Charges for expenses from a health department/clinic maintained for employees by an employer, a union, a trustee or similar type of entity.
- Charges for expenses that are reimbursable by any local or other governmental agency, except Medicaid.
- Charges incurred in connection with an injury or illness related to a motor vehicle if the covered person is not in compliance with any State law regulating motor vehicle insurance coverage.

M. SPINAL TREATMENT SERVICES

- Charges for spinal manipulation services that exceed the visit limits specified in the Schedule of Benefits.
- Charges for any spinal manipulation service not related to the spine.
- Charges for supplements, drugs, medical equipment, or supplies dispensed by or prescribed by a spinal treatment provider.
- Charges for laboratory services provided or ordered by a spinal treatment provider.
- Charges for consultations provided by a spinal treatment provider.
- Charges for rehabilitative exercise not related to spinal subluxations or spinal misalignments.
- Charges for treatment of fractures and dislocations of the extremities provided by a spinal treatment provider.
- Charges for nutritional advice provided by a spinal treatment provider.

N. TRANSPLANTS

- Charges for transplant services not listed under the chapter, ELIGIBLE MEDICAL EXPENSES.
- Charges for health services for transplants involving mechanical or animal organs.
- Charges for transplant services that are not performed at a Designated Facility. (This exclusion does not apply to corneal transplants.)
- Charges for any solid organ transplant that is performed as a treatment for cancer.

O. TRAVEL

- Charges for health services provided in a foreign country, unless required due to an injury, urgent condition, or emergent illness. Charges incurred outside the United States if the covered person traveled to such a location for the primary purpose of obtaining medical services, drugs, or supplies.
- Charges for travel, room, and board, lodging or transportation expenses, even though prescribed by a physician or necessitated due to where treatment is received.

P. VISION AND HEARING

- Charges for routine eye examinations.
- Charges for the purchase or fitting of hearing aids.
- Charges for the purchase or fitting of eye glasses or contact lenses.
- Charges for eye exercise therapy or vision therapy.
- Charges for radial keratotomy or similar eye surgeries.

Q. ALL OTHER EXCLUSIONS

- Charges incurred by a spouse if the guidelines of the Spousal Access Provision (see the chapter, ELIGIBILITY PROVISIONS) are not followed.

- Charges for any services, supplies or treatments that are not deemed medically necessary or that are not consistent with current standards of acceptable medical treatment.
- Charges for complications as a result of non-pre-authorized services.
- Charges for physical, psychiatric, or psychological exams, testing, vaccinations, immunizations or treatments when:
  - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage, or adoption.
  - Required for pre-employment or premarital examinations.
  - Related to judicial or administrative proceedings or orders.
  - Conducted for purposes of medical research, unless stated as covered.
  - Required to obtain or maintain a license of any type.
  - Required for testing or training done for educational purposes, except as allowed for nutritional and health education counseling.
- Charges due to war or any act of war, whether declared or undeclared.
- Charges that are incurred before a person is enrolled under this Plan. Charges which are incurred after the individual ceases to be an enrolled person except as permitted by the Continuation of Benefits (COBRA) provision of this Plan.
- Charges for which a covered person would not legally have to pay if there were no coverage.
- In the event that a provider waives co-pays or coinsurance amounts for a particular health service, no benefits are provided for the health service for which the co-pays or coinsurance amounts are waived.
- Charges incurred in excess of any plan maximums.
- Charges for services and supplies, which are provided while claimant is in the custody of any law enforcement authorities or while incarcerated.
- Charges for ambulance services when neither treatment nor transport is provided.
- Services provided by fire departments, rescue squads, or other emergency transport providers that are supported by a government or where fees are in the form of a voluntary donation.
- Ambulance transport (ground, water, or air) that is not to the closest Hospital equipped to treat the condition, including transport to a preferred Hospital or for the convenience of being closer to your home or someone to provide continuing care to you.
- Charges for services and supplies for home births.
- Charges for birthing centers.
- Charges for private duty nursing.
- Charges for custodial care.
- Charges for domiciliary care.

- Charges for rest cures.
- Charges for psychosurgery.
- Charges for the services of personal care attendants.
- Charges for work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).
- Charges for autopsy.
- Charges for long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood, and blood products.
- Charges for medical and surgical treatment for snoring or daytime sleepiness, except when provided as a part of treatment for documented obstructive sleep apnea.
- Charges for oral appliances for snoring.
- Charges for speech therapy (except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, or a congenital anomaly) for:
  - ADD/ADHD.
  - Learning disabilities.
  - Developmental delays.
  - Hearing loss associated with chronic ear infections.
- Charges for physical therapy or occupational therapy for learning disabilities or developmental delays.
- Charges for all devices and computers, including electronic access/connectivity, to assist in communication, speech, and telemedicine services, for example special TV used for closed caption and reading machines, except for speech aid prosthetics and tracheo-esophageal voice prosthetics.
- Charges for gym memberships. Aquatic exercise programs or classes. Personal trainers. Exercise equipment, for example treadmills or pools, even if prescribed by a physician.
- Charges for inpatient or outpatient recreational therapy.
- Charges for penile implants for the treatment of impotence having a psychological origin.
- Charges for legal/court fees, copy/fax fees, late fees, shipping charges, long distance telephone charges, or fees for copying X-rays. Charges in connection with the preparation of reports, claim forms or any other necessary documentation, or charges for appointments that are not kept.
- Charges for power operated wheel chairs if you:
  - Can walk, or
  - Can use a manual wheelchair, or
  - Only need it for leisure activities, or

- Would not need it for use in your home.

- Charges for any of the following:
  - All bath aids, for example, shower chairs and safety rails
  - Toilet seat riser
  - Grabbers
  - Stair lifts
  - Ramps
  - Diapers
  - Home modifications
  - Wheelchair lifts
  - Lift chairs
  - Standing systems, stationary and mobile
  - Automobile modifications and adaptive devices, for example hand grips, hand controls and special foot pedals.
  - Mobility carts and power-operated vehicles, for example scooters, motorized carts, and electric scooters.
  - Car seats and/or safety seats
  - Strollers
  - Shoe lifts
  - Temper-pedic and all other mattresses
  - Air conditioners. Air purifiers and filters or air cleaning devices. Dehumidifiers and humidifiers.
  - Batteries and battery chargers.
  - Hot tubs and whirlpools. Tanning beds, lamps and services. Light bulbs and short and long wave UV light units to be used in the home.
- Charges involving a covered person's medical condition, which arise out of the commission of a felony by such a covered person, if convicted, unless resulting from an underlying medical condition or act of domestic violence.
- Charges for mouth orthotics, mouth splints, mouth prosthetics and mouth appliances.
- Charges for the treatment of an overbite or underbite. Maxillary and mandibulary osteotomies, unless medically necessary.
- Charges for services, care, supplies, or devices not prescribed by a licensed physician.
- Charges for an intern or resident physician or any hospital or medical staff in a training capacity.
- Charges for inpatient hospital expenses related to physical conditions which do not require substantial continuous bed care under the constant supervision of doctors and

nurses, or inpatient hospital expenses arising out of bed-confinement primarily for the purpose of a routine or periodic physical exam.

- Charges for weekend admissions – hospital room and board, other services, or supplies, or treatment will not be paid by the Plan if incurred during the first weekend of any inpatient stay in a hospital or other covered institution if the stay begins on that weekend (Friday, Saturday, or Sunday before noon). This will not apply if:
  - The admission is needed for observation with medical cause; or
  - Surgery or therapy is done within 24 hours of admission; or
  - The admission is due to a medical emergency.
- Charges for treatment of: (a) weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations and orthotics); (b) corns, calluses or toenails (except the removal of nail roots and necessary services in the treatment of metabolic or peripheral vascular services).
- Charges for audio therapy.
- Charges for items or services furnished, ordered, or prescribed by any provider that involves fraud.
- Charges for reversal of gender reassignment surgery.
- Heath care services, medical supplies, and medications that do not meet the definition of a Covered Health Service.
- Health care services, medical supplies, and medications for which medical criteria have not been met.

QUESTIONS, GRIEVANCES, APPEALS, AND COMPLAINTS

We encourage your comments and suggestions so that University of Michigan Health Service Company, as the Claims Administrator, may continue to improve its service to you. While we hope that there are no problems with our services, one may occasionally arise. In this case, there is a grievance procedure that provides a full and fair investigation to resolve your problem as rapidly and efficiently as possible. This procedure is required under the Affordable Care Act.

We and the Claims Administrator interpret and administer the terms of this Plan. Any adverse decisions regarding benefits are subject to your right to appeal under applicable law.

NOTE: ANY GRIEVANCE FILED UNDER THIS CHAPTER DUE TO AN ADVERSE BENEFIT DETERMINATION MUST BE FILED WITHIN 180 DAYS WITH THE CLAIMS ADMINISTRATOR FOLLOWING NOTICE OF THE ADVERSE BENEFIT DETERMINATION.

TERMS USED IN THIS PROCESS

The terms used in this chapter mean:

Adverse Benefit Determination – a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a Benefit. This includes any such denial, reduction, termination, or failure to provide or make payment that is based on:

- A determination of eligibility to participate in the plan; or
- A Rescission of coverage; or
- A Benefit resulting from the application of any utilization review; or
- Failure to cover an item or service for which Benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or not medically appropriate.

Authorized Representative –

- A person (including but not limited to a Physician) to whom a Covered Person has authorized in writing to act on his or her behalf at any stage in the Grievance process.
- A person authorized by law to provide substituted consent for a Covered Person; or
- A family member of the Covered Person or the Covered Person's treating health care professional if the Covered Person is unable to provide consent.

Complaint – a written or verbal expression of dissatisfaction about any matter **other than** an action subject to appeal such as a complaint about quality of care, quality of service or an administrative complaint.

Concurrent Care – an on-going course of treatment previously approved for a specific period of time or number of treatments.

Urgent Grievance – a Grievance, for which a Physician has substantiated, verbally or in writing, that the timeframe for the normal Grievance procedure would seriously jeopardize

the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function.

Grievance/Appeal – a written expression of dissatisfaction by a Covered Person or Authorized Representative concerning an Adverse Benefit Determination of a Pre-Service, Post-Service, or Concurrent Care Claim. The terms "Appeal" and "Grievance" are used interchangeably.

Post-Service Claim – a claim that is filed for payment of Benefits after medical care has been received.

Pre-Service Claim – a claim that requires authorization before receiving medical care as a condition for receipt of Benefits.

Urgent Pre-Service Claim – a claim that requires authorization before receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function without the care or treatment that is requested.

WHAT TO DO FIRST

If you have a complaint about the quality of service or care that you receive, the Claims Administrator wants to hear from you. Please contact Customer Service at the phone number shown on your ID card. University of Michigan Health Service Company follows up on all complaints.

If you have a concern or question about a benefit determination, you may informally contact Customer Service before requesting a formal grievance. If the Customer Service specialist cannot resolve the issue to your satisfaction over the telephone, you may submit your question in writing.

However, if you are not satisfied with a benefit determination you may submit a grievance as described below, without first informally contacting Customer Service. If you first informally contact Customer Service and later wish to request a formal grievance, you can contact Customer Service and a Customer Service specialist will provide you with the appropriate information to request a formal grievance.

If you are appealing an urgent pre-service claim denial, please refer to the section below, URGENT CLAIM APPEALS OF PRE-SERVICE CLAIMS THAT REQUIRE IMMEDIATE ACTION and contact Customer Service immediately.

Customer Service specialists are available to take your call during regular business hours, Monday through Friday.

HOW TO REQUEST A FORMAL GRIEVANCE

If you are not satisfied with the resolution of your grievance through informal procedures, you have the right to request (in writing) a formal review of your grievance. Contact Customer Service to obtain the information needed to initiate the internal grievance process. This process must be initiated in writing within 180 days following notice of the adverse benefit determination. You may authorize, in writing, an authorized representative to act on your behalf at any stage of the grievance process.

If the grievance request relates to a claim for payment, your request should include:

- The patient's name and Team Member number from the ID card;

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

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

GRIEVANCE PROCESS – STEP 1

University of Michigan Health Service Company will let you know within five calendar days from the date they receive your grievance that the grievance has been received, and will inform you or your authorized representative of the outcome within 15 calendar days for pre-service claims or 20 calendar days for post-service claims. If your grievance 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. By requesting a grievance, you consent to this referral and the sharing of pertinent medical claim information.

Upon request, and free of charge, you have the right to reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. If we obtain additional information during the course of the review, they will provide you a copy of this information free of charge. You or your authorized representative will have the right to present your grievance and to provide written comments, documents, records, or other additional information relating to the claim.

All comments, documents, records and other information submitted is taken into account without regard to whether such information was submitted or considered in the adverse benefit determination.

GRIEVANCE PROCESS – STEP 2

If you are dissatisfied with the decision on your issue in Step 1, your grievance rights include your right to appear before a Board of Directors, or designated committee, or right to a managerial level conference to present your grievance. This is referred to as a hearing.

You must initiate this hearing process within 60 days from the date of the letter in Step 1 (outlined above). You may participate in the hearing in person or by teleconference. If you initiate a grievance hearing, a committee of qualified individuals, who were not involved in the decision being appealed, will be appointed by the Claims Administrator to decide the grievance. The committee may consult with, or seek the participation of, medical experts as part of the grievance resolution process.

You must complete Step 1 of the grievance Process before proceeding to Step 2. You or your authorized representative will be informed of the outcome of this hearing within ten calendar days.

GRIEVANCE DETERMINATIONS

Pre-Service and Post-Service Claim Appeals

Once the grievance is initiated, you will be provided with written or electronic notification of the determination within a total of 30 days from receipt of the grievance request. Notification of the determination of Step 1 will be sent within 15 calendar days for pre-service claims or within 20 calendar days for post-service claims, and notification of the determination of Step 2 will be sent within ten calendar days.

For procedures associated with urgent pre-service claims, see the section, URGENT CLAIM APPEALS OF PRE-SERVICE CLAIMS THAT REQUIRE IMMEDIATE ACTION below.

Urgent Claim Appeals of Pre-Service Claims That Require Immediate Action

Your appeal of a pre-service claim may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function without the care or treatment that is requested.

In these urgent situations:

- The appeal does not need to be submitted in writing.
- You or your physician should call us as soon as possible.

University of Michigan Health Service Company will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition. If you wish to seek external review by an independent review organization for an urgent claim, you may ask for review at the same time that you go through the internal grievance process (see the following section, EXTERNAL REVIEW RIGHTS, below). If you do not request an independent review at the same time as the internal grievance process and you later wish to seek external review, the Claims Administrator will facilitate the external review.

EXTERNAL REVIEW RIGHTS

You have the right to external review if you are not satisfied with the decision following the initial appeal. You must file your request for external review within four months (or 127 days) of the appeal determination.

The Claims Administrator will complete a preliminary review of the request for an independent external review within five business days of receipt and notify you of the findings within one business day upon completion of the preliminary review.

If additional information is required, you will be asked to provide the additional information. You must provide the additional information within seven business days.

The Claims Administrator will provide you with the name of the independent review organization (IRO) assigned to conduct the independent external review.

The IRO must make a decision on the request within 45 days of receipt.

You may request an external review if the Claims Administrator makes an error while reviewing your appeal. The error must not be minor, non-prejudicial and attributable to a good cause and matters beyond the Plan's control.

YOUR RIGHT TO BRING CIVIL SUIT

- You have the right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review; and
- After you have exhausted all available Plan procedures before filing suit; and
- Other voluntary alternative dispute resolutions may be available. You should contact the local office of the DOL or the state insurance regulatory agency as indicated within the Detailed Benefit Booklet. Copies of the documents, records and other information relevant to the denied claim shall be made available to you at no charge, upon written request.

CLAIM FILING PROCEDURE

University of Michigan Health Service Company of Lansing, Michigan will process your claims.

PLEASE FOLLOW THESE INSTRUCTIONS CAREFULLY. THIS WILL ASSURE PROMPT PAYMENT OF YOUR CLAIMS.

MEDICAL EXPENSES

- Hospital services (in- or outpatient)

When hospital services are rendered, present your identification card. The hospital will send the bill to University of Michigan Health Service Company. We will send the payment directly to the hospital.

- Prescription drugs

You must follow the instructions listed below for submitting your claim:

- Always present your ID card at the pharmacy.
- Only use the claim form available on our web site at www.uofmhealthplan.org when you have paid full price for a prescription drug order at the pharmacy because:
  - The pharmacy does not accept your ID card and you are receiving a prescription drug for an urgent or emergent purpose and you must submit the receipt to University of Michigan Health Service Company directly (see address below); or
  - You have not received your ID card (submit to Express Scripts at address below)
- You must complete a separate claim form for each pharmacy used and for each patient.
- You must submit claims within one year of date of purchase.
- Be sure your receipts are complete and contain the information listed above.
- Read the acknowledgement on the claim form carefully, and then sign and date the form. (If authorization is required, you must have authorization prior to submission of the receipt or the request will be denied)
- Return the completed form and receipt to:

  EXPRESS SCRIPTS

  Attn: Commercial Claims
  P.O. Box 14711
  Lexington, KY 40512-4711

- When you request payment of benefits from us for covered prescription drug products provided by an out-of-network pharmacy in an emergency or urgent situation, you must follow the same instructions described above but return the claim form and receipts to us at:

  UNIVERSITY OF MICHIGAN HEALTH SERVICE COMPANY
  P.O. BOX 30377
  LANSING MI 48909-7877

- SPN/SCN network providers (in-network)
  - Present your medical identification card. The SPN/SCN provider will submit the bill to:

    UNIVERSITY OF MICHIGAN HEALTH SERVICE COMPANY
    EDI PAYOR ID 37330
    PO BOX 313
    GLEN BURNIE, MD 21060-0313

- All other providers (out-of-network)
  - Have the provider of service send the itemized bill to Zelis Healthcare. Be sure the following is included on the bill:
    - Team Member's name.
    - Team Member's Identification Number.
    - University of Michigan Health-Sparrow.
  - If the bill is sent to your home, submit the itemized bill to Zelis Healthcare:

    ZELIS HEALTHCARE
    EDI PAYOR ID: 07689
    PO BOX 247
    ALPHARETTA GA 30009-2407

ORIGINAL BILLS

Submit only the original bills. Keep copies for your records or your spouse's insurance. Copies will be accepted only if the University of Michigan Health-Sparrow Medical Plan is secondary in coordination.

ITEMIZED BILLS

Medical Claims – Your Plan requires that all medical bills be itemized. University of Michigan Health Service Company will process only itemized bills.

The bill must include:

- Patient's name
- Team Member name and ID number
- Date of service
- Services rendered with procedure and diagnosis codes
- Amount charged for each service performed
- Provider's name, address and provider identification number

Prescription Drug Claims – When you request reimbursement for covered Prescription Drug Products obtained from a Network Pharmacy, you must provide our Pharmacy Benefits Manager, Express Scripts with the following information and documentation:

- Patient's name and date of birth
- Date the prescription was filled

- Name and address of the pharmacy
- Prescribing Physician's name or ID number
- NDC number of the drug
- Name of the drug and its strength
- Quantity and days' supply
- Prescription number
- DAW (Dispense As Written), if applicable
- Amount paid

NOTE: A pharmacist can provide the necessary information if your claim or bill is not itemized.

ACCIDENT EXPENSES

Accident-related bills must have the following information: WHEN, WHERE, AND HOW THE ACCIDENT HAPPENED.

THE BILL(S) WILL NOT BE PROCESSED WITHOUT THIS INFORMATION.

AUTOMATIC ASSIGNMENT OF BENEFITS

- Unpaid bills - Payment of all unpaid bills will be made payable to the provider of service and mailed to the provider.
- Paid bills - Payment of all paid bills will be made payable to the Team Member and mailed to the Team Member. If you have paid the bill, be sure "paid" is indicated on the bill.

EXPLANATION OF BENEFITS

Each time University of Michigan Health Service Company processes a claim for you or a member of your family, they will respond with an Explanation of Benefits informing the patient what the charges were, how the charges were paid, and to whom the payments were made.

DEADLINE FOR FILING CLAIMS

You and your covered dependents must file any medical claim in accordance with the above procedure within 15 months of the date of service in order for such claim to be considered an allowable expense under this Plan.

COORDINATION OF BENEFITS

If you are covered by two plans (this Plan and your spouse's plan), both plans may pay. However, the combination of payment from both plans cannot exceed 100%.

File your claims in the following manner:

- Team Members of University of Michigan Health-Sparrow

Submit your original bills to University of Michigan Health Service Company. Keep copies of the bills. When you receive the explanation of benefits, send a copy of the bill(s) and a copy of the explanation of benefits to your spouse's insurance company.

- Your spouse if covered by another employer's plan

Your spouse should send his/her bills to his/her insurance company first and University of Michigan Health Service Company second. Send us a copy of the explanation of benefits from his/her insurance company and a copy of the bill(s).

- Children

If children are covered by both parents' plans and the parents are not divorced or separated, the plan of the parent with the birth date earliest in the calendar year will pay first. The plan of the parent with the later birth date will pay second.

- Divorce

If there is no court order or decree stating the order of coverage for dependent children covered under more than one plan, this Plan follows the first applicable rule under the National Association of Insurance Commissioners (NAIC) Model Coordination of Benefits Rules as detailed in the chapter, COORDINATION OF BENEFITS later in this document.

- Motor Vehicle Accidents

This Plan will pay for eligible expenses in connection with motor vehicle-related accidents/injuries only after all other available benefits have been exhausted including any benefits available from an automobile insurance policy.

However, this Plan will not pay any charges incurred in connection with any injury or illness related to a motor vehicle if the covered person is not in compliance with any State law regulating motor vehicle insurance coverage (unless auto insurance has lapsed less than 90 days).

- COBRA

A plan that covers the individual as an active employee or dependent of an active employee will be considered to pay its benefits before a plan that covers the individual as a COBRA participant.

GENERAL PLAN INFORMATION

PLAN NAME

University of Michigan Health-Sparrow Medical Plan

TYPE OF PLAN

Welfare Plan providing medical benefits.

PLAN BENEFITS PROVIDED BY

University of Michigan Health-Sparrow

PLAN ADMINISTRATOR AND SPONSOR

University of Michigan Health-Sparrow
1200 East Michigan Avenue
Suite 235
Lansing, Michigan 48912
517-364-5333

CLAIMS ADMINISTRATOR – MEDICAL

University of Michigan Health Service Company
PO Box 30377
Lansing, MI 48912

AGENT FOR SERVICE OF LEGAL PROCESS

University of Michigan Health-Sparrow
1200 East Michigan Avenue
Suite 235
Lansing, Michigan 48912

IRS PLAN NUMBER

509

EMPLOYER IDENTIFICATION NUMBER

38-1360584

PLAN YEAR ENDS

December 31

INSTITUTION HOLDING PLAN FUNDS

PNC Bank

PLAN COSTS

Contributions for participation in this Plan shall be shared by the employer and the Team Members.

FUNDING AND PAYMENT OF CLAIMS

The benefits described herein are self-funded by the employer and are not insured by an insurance company. University of Michigan Health Service Company is a Benefit or Claims Administrator who processes claims and does not insure benefits described in this Plan. If for any reason the Plan Administrator does not ultimately pay expenses under this Plan, the individuals covered by the Plan may be liable for those expenses.

Complete and proper claims for benefits made by individuals covered by the Plan will be promptly processed. In the event there are delays in processing claims, the individuals covered the Plan shall have no greater rights to interest or other remedies against University of Michigan Health Service Company than as otherwise afforded them by law.

PLAN ASSET DISTRIBUTION AFTER TERMINATION OF THE PLAN

Information concerning asset distribution after termination of the Plan shall be made available by the Plan Administrator at no cost upon written request.

GOVERNING LAW

This Agreement shall be governed by and construed under the laws of the State of Michigan to the extent not preempted by Federal law.

RIGHTS RESERVED

The right is reserved in the Plan for the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan and any or all benefits provided under the Plan, covering any active Team Member or current or future retiree or dependent in whole or in part at any time. Any such change or termination in benefits will be based solely on the decision of the Plan Sponsor and may apply to all eligible active and non-active Team Members and dependents as either separate groups or as one group, regardless of status. For the Union Team Members, this Plan is maintained pursuant to a collective bargaining agreement, as applicable.

When changes are made to University of Michigan Health-Sparrow benefit plan(s) covered by the Employee's Retirement Income Security Act (ERISA) programs, they are made in the form of amendments and/or summaries of material modification. The procedure for amending an ERISA plan is as follows:

- The proposed amendment request by the Plan Sponsor is sent to the Claims Administrator of the ERISA plan.
- The Claims Administrator develops an amendment and/or summary of material modification in accordance with the amendment request from the Plan Sponsor. The Vice President, Human Resources of University of Michigan Health-Sparrow will then approve and sign the amendment and/or summary of material modification.
- The approved amendment and/or summary of material modification becomes part of the summary plan description and is available to the Department of Labor upon request. Adoption of an amendment and/or summary of material modification shall be effective immediately upon approval by the Plan Sponsor. Alternatively, the amendment and/or summary of material modification shall be retroactively effective (to the extent permitted by law) if the amendment and/or summary of material modification

so states. The Plan Sponsor will notify plan participants of the amendment and/or summary of material modification, in writing.

NAMED FIDUCIARY

University of Michigan Health-Sparrow
1200 East Michigan Avenue
Suite 235
Lansing, Michigan 48912
517-364-5333

The Plan has granted the Plan Fiduciary final discretionary authority in determining eligibility for benefits or to interpret the terms of the Plan for claims purposes.

EMPLOYEE BENEFITS SECURITY ADMINISTRATION

For additional information on ERISA and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), please contact the following:

Michigan residents

Employee Benefits Security Administration
211 W. Fort Street, Suite 1310
Detroit, Michigan 48226-3211
(313) 226-7450

Non-Michigan residents

Employee Benefits Security Administration
200 Constitution Avenue, NW
Room N56226
Washington, D.C. 20210
(202) 219-8776

COORDINATION OF BENEFITS

NOTE: This Plan is intended to comply with the National Association of Insurance Commissioners (NAIC) Model Coordination of Benefits Rules.

The Coordination of Benefits provision applies when the Team Member or any person in his family is covered by this Plan and is covered by any other health care plan(s). This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses.

If two Team Members are married and either or both are covered under the other's plan, this Plan will coordinate medical benefit payments within this contract. This shall also apply to any eligible dependent children covered under both parents' plan. This provision shall apply to any eligible dependent children of two unmarried Team Members who are both covered under this Plan.

The Coordination of Benefits provision does not apply to outpatient Prescription Drug Products managed by the Pharmacy Benefit Manager. Prescription Drug Product Benefits will not be coordinated with those of any other health coverage plan nor will co-pays be reimbursed under this Plan.

In no event will this Plan coordinate benefits for expenses that are not considered "allowable expenses" under the terms and conditions of this Plan. "Allowable expense" shall be deemed to mean any necessary, reasonable, and customary item of expense for services, supplies, or treatment which is covered under this Plan. "Plan" shall be deemed to mean any plan providing benefits or services by health care coverage or any other arrangement of coverage for individuals in a group, whether on an insured or an uninsured basis, including any governmental program (except Medicaid) or coverage required or provided by statute.

ORDER OF PAYMENT

According to the following section outlining the order of payment, one plan will be designated as the "primary plan" and succeeding plans will be designated as "secondary plans."

The "primary plan" will pay expenses based on the payment obligations it has established under its Schedule of Benefits, and all "secondary plans" will then adjust their expense payments so that the total benefits available to the covered person will not exceed the benefit allowable under the Coordination of Benefits Provisions of the Plan. This Plan will never pay more than it would without this coordination provision.

When a person is covered under two or more plans, the rules below will apply to decide which plan's benefits are payable first:

1. A plan with no provision for coordination of benefits will be considered to pay its benefits before a plan that contains such a provision.
2. A plan that covers an individual as other than a dependent (e.g., as an employee, member, subscriber, retiree) is primary and the plan that covers the person as a dependent is secondary.

3. The Plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary. 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. Coverage provided to an individual as a retired worker, and as a dependent of an actively at work spouse will be determined under Rule #2.
4. If two plans cover a dependent child, the plan of the person whose birthday anniversary occurs earlier in the calendar year shall be primary if:
    - The parents are married; or
    - The parents are not separated (whether or not they have ever been married); or
    - A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

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

5. If the parents are not married or are separated (whether or not they were ever married) or are divorced:
    - If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary.
    - If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary. This subparagraph shall not apply with respect to any claim determination period or plan year during which the benefits are paid or provided before the entity has actual knowledge of the court decree provision.
    - If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Rule #4 above determine the order of benefits.
    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expense or health care coverage of the dependent child, the provisions of Rule #4 above determine the order of benefits.
    - If there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parent's spouse (if any) is:
        - The plan of the custodial parent
        - The plan of the spouse of the custodial parent
        - The plan of the non-custodial parent
        - The plan of the spouse of the non-custodial parent
    - For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Rules #4 or 5 above as if those individuals were parents of the child.

- For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in Rule #7 below applies.
- In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in 4a-c above to the dependent child's parent(s) and the dependent's spouse.

6. If a person whose coverage is provided under a right of continuation pursuant to state or federal law (e.g., COBRA) is also covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If the other 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.
7. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is primary.
   - To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the covered person was eligible under the second within 24 hours after the first ended.
   - The start of a new plan does not include:
     - A change in the amount of scope of a plan's benefits; or
     - A change in the entity that pays, provides, or administers the plan's benefits; or
     - A change from one type of plan to another (such as from a single employer plan to that of a multiple employer plan).
   - A person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.
8. If another plan contains a provision whereby such plan considers their plan to be excess of other available benefits or considers their plan to be secondary only in normal coordination of benefits situations, this plan will coordinate to consider benefits payable on a 50%/50% basis, between this plan and the other plan.
9. If none of these preceding rules determines the primary plan, the allowable expenses shall be determined equally between the plans.

The total maximum benefit limits under this Plan will only be reduced by the charges actually paid by this Plan. Any benefits coordinated and paid by other coverage providers will not be charged against the benefit limits of this Plan.

AUTOMOBILE INSURANCE, INCLUDING NO-FAULT INSURANCE

This Plan will pay for eligible expenses in connection with motor vehicle-related accidents/injuries only after all other available benefits have been exhausted including any benefits available from an automobile insurance policy.

If you do not elect primary medical insurance under your automobile policy, all medical expenses will be considered ineligible under this Plan, and no payments will be made on your claim(s).

However, this Plan will not pay any charges incurred in connection with any injury or illness related to a motor vehicle if the covered person is not in compliance with any State law regulating motor vehicle insurance coverage (unless auto insurance has lapsed less than 90 days).

MEDICARE

This Plan is intended to comply with Federal Regulations as they apply to ERISA Plans with respect to Medicare coverage and coordination of benefits.

If Medicare is the primary coverage and this Plan is the secondary coverage, this Plan assumes that the covered person has full medical coverage (that is, both Part A and Part B). If proof of Medicare payment (such as an EOMB) cannot be supplied, the covered person may be responsible for all charges.

In the case of services and supplies for which Medicare makes direct reimbursement to the health care provider, this Plan will coordinate its benefits based on the amount approved by Medicare and not the amount of the charge.

COORDINATION WITH MEDICAID

Notwithstanding any other provisions of this Plan to the contrary, this Plan shall not take into account that a covered person or covered person’s beneficiary qualifies for medical assistance under a State Medicaid plan when determining eligibility for Plan enrollment or the payment of Plan benefits.

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985, AS AMENDED (COBRA) :

YOUR CONTINUATION COVERAGE RIGHTS

NOTE**:** COBRA administration, in accordance with federal law, remains the sole responsibility of the Plan Administrator as fiduciary of the Plan, even when COBRA administration functions are contracted to a third party (“agent”). University of Michigan Health Service Company is the ministerial agent and the benefits administrator for the Plan Administrator and the Plan.

If you, your spouse, or your dependent children are covered under the Plan and coverage under the Plan terminates due to certain events described below (commonly referred to as "qualifying events"), you may elect to continue such coverage under the federal law enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, known as "COBRA." Qualified beneficiaries entitled to COBRA coverage may include you, your spouse, or your dependent children depending on the type of qualifying event. Qualified beneficiaries also may include children born to or placed for adoption with the “covered employee” during a period of COBRA continuation coverage.

QUALIFYING EVENTS

IF YOU ARE AN EMPLOYEE
You have a right to COBRA coverage if you *lose your Plan coverage** because of any of the following qualifying events: • A reduction in your hours of employment with the employer; or • The termination of your employment with the employer for reasons other than gross misconduct on your part. ***The 1999 Final COBRA Regulations state “to lose coverage” means to cease to be covered under the same terms and conditions as in effect immediately before the event. The Final Regulation clarifies that a loss of coverage includes an increase in an employee premium or contribution resulting from one of the events described above.

IF YOU ARE THE SPOUSE OF AN EMPLOYEE
You have the right to COBRA coverage if you *lose your Plan coverage** because of any of the following qualifying events: • The death of your employee-spouse; • A termination of your employee-spouse's employment with the employer (for reasons other than gross misconduct) or reduction in your employee-spouse's hours of employment with the employer; • Your employee-spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

- Divorce or legal separation from your employee-spouse.

(continued on next page)

IF YOU ARE THE SPOUSE OF AN EMPLOYEE

NOTE: If your spouse (the employee) reduces or eliminates your coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the actual event. There is no obligation to offer coverage during the period between your termination from the Plan and the divorce.

*The 1999 Final COBRA Regulations state “to lose coverage” means to cease to be covered under the same terms and conditions as in effect immediately before the event. The Final Regulation clarifies that a loss of coverage includes an increase in an employee premium or contribution resulting from one of the events described above.

IF YOU ARE A DEPENDENT CHILD OF AN EMPLOYEE

You have the right to COBRA coverage if you *lose your Plan coverage** because of any of the following qualifying events:

- The death of your parent-employee;
- A termination of your parent-employee's employment with the employer (for reasons other than gross misconduct) or reduction in your parent-employee's hours of employment with the employer;
- Your parent-employee's divorce or legal separation;
- You no longer qualify as an eligible dependent child under the Plan; or
- Your parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both).

*The 1999 Final COBRA Regulations state “to lose coverage” means to cease to be covered under the same terms and conditions as in effect immediately before the event. The Final Regulation clarifies that a loss of coverage includes an increase in an employee premium or contribution resulting from one of the events described above.

ELECTING COBRA AFTER FMLA

If you take FMLA leave and do not return to work at the end of the leave, you (and your covered spouse and dependent children) will be entitled to elect COBRA if:

- They were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and
- They will lose Plan coverage within 18 months because of your failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect

COBRA at the end of an FMLA leave even if they were not covered under the Plan during the leave.)

COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours. (See the section below entitled, DURATION OF COBRA COVERAGE.)

SPECIAL SECOND ELECTION PERIOD

Special COBRA rights apply to certain employees and former employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA). These individuals are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which an eligible employee or former employee becomes eligible for TAA or ATAA, but only if the election is made within the six months immediately after the individual's group health plan coverage ended. If you are an employee or former employee and you qualify or may qualify for TAA or ATAA, contact the Plan Administrator using the Plan contact information provided below. *Contact the Plan Administrator promptly after qualifying for TAA or ATAA or you will lose the right to elect COBRA during a special second election period.*

COBRA COVERAGE

COBRA coverage is coverage that, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or dependents. In most cases, this means you will have the same coverage under COBRA as you did before the qualifying event. Contact the Plan Administrator for more details.

You do not have to show evidence of good health to elect COBRA coverage. However, COBRA coverage is provided subject to your eligibility for that coverage; the Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible. This cancellation right applies even if the Plan Administrator previously accepted one or more of your COBRA premium payments.

Alternative coverage is coverage provided to a qualified beneficiary after a qualifying event that is not COBRA coverage. Regardless of whether alternative coverage is available, COBRA coverage must also be made available.

ENROLLMENT OF NEWBORN OR ADOPTED CHILDREN

A newborn child, adopted child, or child placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other qualified beneficiaries. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (e.g., limiting ages).

ELECTING COBRA COVERAGE

In order to obtain COBRA coverage, you, your qualified beneficiaries and the employer must satisfy certain notification requirements.

NOTICE REQUIRED TO BE GIVEN BY QUALIFIED BENEFICIARY

You and your qualified beneficiaries have the responsibility to inform the Plan Administrator of a qualifying event that is:

- A divorce;
- A legal separation; or
- A child losing dependent status under the Plan.

A COBRA election will be available to you only if you *notify the Plan Administrator in writing* within 60 days after the later of:

- The date of the qualifying event; or
- The date on which your Plan coverage ends (or would end) because of the event.

Additionally, to extend COBRA coverage, you must notify the Plan Administrator of any secondary qualifying events or of a determination of disability. In the case of a disability, you also must notify the Plan Administrator when you are no longer disabled. (See the sections below entitled, DISABILITY, SECONDARY QUALIFYING EVENT, and EARLY TERMINATION OF COBRA COVERAGE).

Any notice that you provide to your plan administrator must be in writing. Oral notice, including notice by telephone, is not acceptable. If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must contain the following information:

- The name of the Plan;
- The name and address of the employee covered under the Plan;
- The name(s) and address(es) of the qualified beneficiaries; and
- The qualifying event and the date it occurred.

If the qualifying event is a divorce or legal separation, your notice must include a copy of the divorce decree or the legal separation agreement. If the qualifying event is a child losing dependent status under the Plan, then your notice must state the date the child is no longer eligible and the child's address.

Individuals who can provide this notice include the covered employee or qualified beneficiary with respect to the qualified event, or any representative acting on behalf of the covered employee or qualified beneficiary. The provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the qualifying event.

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NOTICE REQUIRED TO BE GIVEN BY QUALIFIED BENEFICIARY
Mail or hand-deliver the written notice of qualifying event to: PLAN ADMINISTRATOR UNIVERSITY OF MICHIGAN HEALTH-SPARROW 1200 E MICHIGAN AVE SUITE 235 LANSING MI 48912 If you or your dependents do not notify the Plan Administrator in writing of the qualifying event within the required time period, the right to elect COBRA coverage will end.

NOTICE REQUIRED TO BE GIVEN BY THE EMPLOYER
The employer has the responsibility to notify the Plan Administrator of a qualifying event that is: • The employee's death; • The employee's termination (other than by reason of gross misconduct); • The employee's reduction in hours of employment; • The employee's Medicare entitlement (Part A, Part B, or both); or • The Employer's bankruptcy under Chapter 11 of the Federal Bankruptcy Code, with reference to retirees and their dependents. This notice must be provided within 30 days after: • The date of the qualifying event; or • The date of the loss of coverage in cases where continuation coverage shall commence on the date of loss of coverage. • When the Plan Administrator is notified that a qualifying event has happened, the Plan Administrator, or its agent, will in turn notify you and your dependents of the right to elect COBRA coverage. This notice must be provided within 14 days.

HOW TO ELECT COBRA

To elect COBRA, you must complete the Election Form that is part of the Plan's COBRA Notice and submit it to the Plan Administrator. A COBRA Notice will be provided to qualified beneficiaries at the time of a qualifying event. You may also obtain a copy of the COBRA Notice from the Plan Administrator.

Under federal law, you have 60 days to elect COBRA from the later of:

- The date you would lose coverage because of one of the qualifying events described above; or
- The date the Plan Administrator informs you of your COBRA election rights.

If you do not submit the completed Election Form by this date, you will lose your right to elect COBRA coverage.

Mail or hand-deliver the completed Election Form to:

PLAN ADMINISTRATOR
UNIVERSITY OF MICHIGAN HEALTH-SPARROW
1200 E MICHIGAN AVE SUITE 235
LANSING MI 48912

Deadline for COBRA Election

If mailed, your Election Form must be postmarked (and if hand-delivered, your Election Form must be received by the individual at the address specified above) no later than 60 days after the date of the COBRA Notice provided to you at the time of your qualifying event. *If you do not submit a completed Election Form by this due date, you will lose your right to elect COBRA coverage.*

If you reject COBRA before the due date, you may change your mind as long as you furnish a completed Election Form before the due date.

You do not have to send any payment with your Election Form when you elect COBRA. Important additional information about payment for COBRA coverage is included below.

Independent Election Rights

Each qualified beneficiary will have an independent right to elect COBRA. For example, your spouse may elect COBRA even if you do not. COBRA may be elected for only one, several or for all dependent children who are qualified beneficiaries. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all the qualified beneficiaries, and parents or legal guardians may elect COBRA on behalf of a minor child. *Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice will lose his/her right to elect COBRA coverage.*

Notification of Medicare Entitlement

When you complete the election form, you must notify the Plan Administrator, or its agent, if any qualified beneficiary has become entitled to Medicare (Part A, Part B or both) and, if so, the date of Medicare entitlement. If you become entitled to Medicare (or first learn that you are entitled to Medicare) after submitting the election form, immediately notify the Plan Administrator, or its agent, of the date of your Medicare entitlement at the address specified above for delivery of the election form.

COBRA Coverage and Other Coverage or Medicare

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied). See the section below entitled, TERMINATION OF COBRA BEFORE THE MAXIMUM COVERAGE PERIOD.

DURATION OF COBRA COVERAGE

COBRA coverage is measured from the date of your loss of coverage. The duration of your COBRA coverage depends on the reason coverage was lost:

QUALIFYING EVENT (RESULTING IN LOSS OF COVERAGE)	MONTHS OF COBRA COVERAGE
Termination of employment	18
Reduction in Hours	18
Divorce or legal separation	36
Death	36
Loss of Dependent Child Status	36
Medicare Entitlement	36

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described above are maximum coverage periods and the actual duration could vary depending on your actual facts and circumstances. COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the section below entitled TERMINATION OF COBRA BEFORE THE MAXIMUM COVERAGE PERIOD.

Special Rules Regarding the Duration of COBRA

If you are an employee and become entitled to Medicare within the 18-month period preceding your termination of employment or reduction in hours, the COBRA continuation period will be extended for all other qualified beneficiaries (e.g., your covered spouse and dependents) to a maximum period of 36 months from the date of your Medicare entitlement. For example, if you become entitled to Medicare and then terminate employment with the employer six months later, your qualified beneficiaries would be entitled to elect COBRA coverage for a period of 30 months from the date of your termination.

Additionally, the duration of COBRA coverage resulting from termination of employment or reduction in hours may be extended in the case of a Social Security disability determination and in the case of multiple qualifying events. However, in no event will COBRA coverage last beyond 36 months from the date of the original qualifying event that made the qualified beneficiary eligible to elect COBRA coverage.

DISABILITY

If a qualified beneficiary (e.g., the employee or the employee's covered spouse or dependent child) is determined by the Social Security Administration to be disabled and you notify the Plan Administrator, or its agent, in writing in a timely fashion, all the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above).

The disability extension is available only if you notify the Plan Administrator, or its agent, in writing of the Social Security Administration's determination of disability before the end of the first 18 months of continuation coverage and within 60 days after the later of:

- The date of the Social Security Administration's disability determination;
- The date of the covered employee's termination of employment or reduction of hours; or

The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

Mail or hand-deliver the notice of determination of disability ("SSA Award Letter") to:

PLAN ADMINISTRATOR
UNIVERSITY OF MICHIGAN HEALTH-SPARROW
1200 E MICHIGAN AVE SUITE 235
LANSING MI 48912

If this notice is not provided, the right to extend coverage from 18 months to 29 months will be lost.

Any notice that you provide to your plan administrator must be in writing. Oral notice, including notice by telephone, is not acceptable. If mailed, your notice must be postmarked no later than the last day of the required notice period. Additionally, any notice you provide must contain the following information:

- The name of the Plan;
- The name and address of the employee or former employee covered under the Plan;
- The name and address of the disabled qualified beneficiary;
- The date the Social Security Administration made its determination of disability;
- The date the qualified beneficiary becomes disabled;

DISABILITY

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA at the time of this notice; and
- The initial qualifying event and the date it occurred.

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Individuals who can provide this notice include the covered employee or qualified beneficiary with respect to the qualified event, or any representative acting on behalf of the covered employee or qualified beneficiary. The provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries.

SECOND QUALIFYING EVENTS

If you are a qualified beneficiary who is a spouse or dependent child, the 18-month period (or, in the case of a disability extension, the 29-month period) may be extended to 36 months from the date of the employee's termination of employment or reduction in hours if a second qualifying event occurs. A second qualifying event is one of the following that occurs during the original 18-month period:

- Death of the employee;
- The employee's divorce or legal separation;
- A child's loss of dependent status under the Plan; or
- The employee’s entitlement to Medicare (Part A, Part B or both).

These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred.

You or your qualified beneficiary must provide written notification to the Plan Administrator (or its agent) of the second qualifying event within 60 days after the later of:

- The date of the second qualifying event; or
- The date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan).

Mail or hand-deliver the written notice of second qualifying event to:

PLAN ADMINISTRATOR
UNIVERSITY OF MICHIGAN HEALTH-SPARROW
1200 E MICHIGAN AVE SUITE 235
LANSING MI 48912

If this notice is not provided, the right to extend coverage from 18 months to 36 months will be lost.

DISABILITY
• Any notice that you provide to your plan administrator must be in writing. Oral notice, including notice by telephone, is not acceptable. If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must contain the following information: • The name of the Plan; • The name and address of the employee or former employee covered under the Plan; (continued on next page)
• The name(s) and address(es) of the qualified beneficiaries who are receiving COBRA at the time of this notice; and • The initial and secondary qualifying events and the dates they occurred. If the second qualifying event is a divorce or legal separation, your notice must include a copy of the divorce decree or the legal separation agreement. If the second qualifying event is a child losing dependent status under the Plan, then your notice must state the date the child is no longer eligible and the child's address. Individuals who can provide this notice include the covered employee or qualified beneficiary with respect to the qualified event, or any representative acting on behalf of the covered employee or qualified beneficiary. The provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the qualifying event.

COST OF CONTINUATION COVERAGE

Under COBRA, you may have to pay all or part of the premium for your continuation coverage. In addition, the employer may charge you a 2% administration fee during the 18 or 36-month COBRA continuation period. If you and your dependents are entitled to 29 months of continuation coverage on account of disability, the employer may charge a 50% administration fee during the additional 11-month coverage period. The amount of your COBRA premium may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

COBRA Premium Due Date

Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to:

PLAN ADMINISTRATOR
UNIVERSITY OF MICHIGAN HEALTH-SPARROW
1200 E MICHIGAN AVE SUITE 235
LANSING MI 48912
517-364-5333

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any

payment by mailing or hand-delivering a check if your check is returned due to insufficient funds or otherwise.

Generally, your premiums are due on the first of the month. COBRA premiums must be paid by personal check, cash, or certified check. However, there is a 30-day grace period for payment of the regularly scheduled premium. To qualify for the grace period, your premium must be postmarked or received by the Plan Administrator no later than 30 days after the original premium due date. Also, your first COBRA premium is not due until 45 days after you elect COBRA coverage. This means that your premium must be postmarked or received by the Plan Administrator no later than 45 days after the date your election of COBRA coverage is postmarked or received by the Plan Administrator. In addition, your initial premium must cover the entire period from the date of the loss of coverage. For example, if you elect COBRA coverage on the last day of the 60-day COBRA election period, your initial premium payment would be for the first two months of your COBRA coverage.

You have 30 days after a notice of an insignificant underpayment to make up that payment.

When a health care provider inquires as to a qualified beneficiary's coverage status, the Plan is responsible to convey all details regarding the qualified beneficiary's right to coverage during the election period and applicable grace periods.

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election or you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

TERMINATION OF COBRA BEFORE THE MAXIMUM COVERAGE PERIOD

EARLY TERMINATION OF COBRA COVERAGE

Your COBRA coverage will automatically terminate before the end of the maximum period if:

- The premium for your COBRA coverage is not paid in full on time;
- The employer no longer provides group health coverage to any of its employees;
- You become covered, after electing COBRA, under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition you may have or any such pre-existing condition clause does not apply to you under the rules concerning creditable coverage;
- You become entitled to Medicare (under Part A, Part B or both) after electing COBRA; or
- During a disability extension period, you are determined by the Social Security Administration to be no longer disabled. For more information about the disability extension period, see the section above entitled, SPECIAL RULES REGARDING THE DURATION OF COBRA.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

Medicare Entitlement and Coverage Under Another Group Health Plan

- You must notify the Plan Administrator, or its agent, *in writing within 30 days* if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B or both) or becomes covered under another group health plan (but only after any pre-existing condition exclusion period of the other plan is exhausted or satisfied).

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EARLY TERMINATION OF COBRA COVERAGE

- COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of an applicable pre-existing condition exclusion period). University of Michigan Health-Sparrow will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice of Medicare entitlement or other group health plan coverage.

Cessation of Disability

- If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Plan Administrator, or its agent, *in writing within 30 days* after the Social Security Administration's determination that the qualified beneficiary is no longer disabled.
- If the Social Security Administration's determination that the qualified beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the later of:
  - The first day of the month that is more than 30 days after the Social Security Administration's determination; or
  - The end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension.

University of Michigan Health-Sparrow will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice that the disabled qualified beneficiary is no longer disabled. For more information about the disability extension period, see the section above entitled, SPECIAL RULES REGARDING THE DURATION OF COBRA.

Notice Procedures

Mail the written notice of Medicare entitlement, coverage under another group health plan or determination that the qualified beneficiary is no longer disabled to:

PLAN ADMINISTRATOR
UNIVERSITY OF MICHIGAN HEALTH-SPARROW
1200 E MICHIGAN AVE SUITE 235
LANSING MI 48912

Any notice that you provide to your plan administrator must be in writing. Oral notice, including notice by telephone, is not acceptable. If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must contain the following information:

- The name of the Plan;
- The name and address of the employee or former employee covered under the Plan;

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EARLY TERMINATION OF COBRA COVERAGE

- The name(s) and address(es) of the qualified beneficiaries; and
- The initial qualifying event and the subsequent event terminating coverage and the dates they occurred.

Individuals who can provide this notice include the covered employee or qualified beneficiary, or any representative acting on behalf of the covered employee or qualified beneficiary. The provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries.

QUESTIONS AND ADDITIONAL INFORMATION

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices or correspondence you send to the Plan Administrator, or its agent.

Questions concerning your Plan or your COBRA rights should be addressed to the contact or contacts identified below.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site.)

You may obtain information about the Plan and COBRA coverage on request from:

COBRA Representative
University of Michigan Health-Sparrow
1200 East Michigan Avenue
Suite 235
Lansing, Michigan 48912
517-364-5333

The contact information for the Plan may change from time to time. The most recent information will be included in the Plan's most recent Summary Plan Description (if you are not sure whether this is the Plan's most recent Summary Plan Description, you may request the most recent copy from the Plan Administrator).

GENERAL PROVISIONS

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For purposes of determining the applicability of and implementing the terms of this provision or any similar provision of any other Plan, the Claims Administrator may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person, any information with respect to any person whom the Plan Administrator deems to be necessary for such purposes. Any person claiming benefits under this Plan must furnish the Claims Administrator such information as may be necessary to implement this provision.

FACILITY OF PAYMENT

Whenever payments that should have been made under this Plan in accordance with its provisions have been made under any other plans, the employer shall have the right, exercisable alone and in its full discretion, to pay over to any organizations making such other payments any amounts it shall deem to be warranted in order to satisfy the intent of this provision, and any amount so paid shall be deemed to be benefits paid under this Plan and to the extent of such payments, the employer shall be fully discharged from liability under this Plan.

RIGHT OF RECOVERY

Whenever payments have been made by the Claims Administrator with respect to allowable expenses in an amount that is, at any time, in excess of the maximum amount of payment necessary to satisfy the intent of this provision, the Claims Administrator will have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments were made, any other insurance companies, including but not limited to Worker's Compensation carriers, and any other organizations.

If an overpayment is made in the opinion of the Plan Administrator, this Plan has the right to recover the overpayment. If a covered person is paid more than allowed by this Plan, the covered person must refund that overpayment. A request for refund will be made in writing by this Plan. If an overpayment is made by the Plan on behalf of the covered person to a hospital, physician, or other covered provider, this Plan may request a refund of the overpayment from either the covered person or the covered provider. If the refund is not received from either the covered person or the covered provider, the overpayment will be deducted from any future Plan benefits available to the covered person or collected through legal process.

STATE RECOVERY OF MEDICAID PAYMENTS

Notwithstanding any other provisions of the Plan to the contrary, if this Plan provides benefit payments on behalf of a covered person who is also covered by a State's Medicaid program, the Plan shall be subject to the State's right to reimbursement for benefits the State has paid on behalf of the covered person, provided that the State has an assignment of rights made by or on behalf of the covered person, or the covered person's beneficiary, as may be required by the State Medical Assistance Plan.

SUBROGATION, REIMBURSEMENT AND THIRD PARTY RECOVERY PROVISION

If you, your spouse, one of your dependents, or anyone who receives benefits under this Plan becomes ill or is injured and entitled to receive money from any source, including but not limited to any party's liability insurance or uninsured/underinsured motorist proceeds, then the benefits provided or to be provided by the Plan are secondary, not primary, and will be paid only if you fully cooperate with the terms and conditions of the Plan.

As a condition of receiving benefits under this Plan, the Team Member or covered person agrees that acceptance of benefits is constructive notice of this provision in its entirety and agrees to reimburse the Plan 100% of benefits provided without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The person receiving benefits further agrees that any funds received by said person and/or their attorney, if any, from any source for any purpose shall be held in trust until such time as the obligation under this provision is fully satisfied. If the Team Member or covered person retains an attorney, then the Team Member or covered person agrees to only retain one who will not assert the Common Fund or Made-Whole Doctrines. Reimbursement shall be made immediately upon collection of any sum(s) recovered regardless of its legal, financial or other sufficiency. If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of State law and/or whether the minor's representative has access or control of any recovery funds.

The Team Member or covered person agrees to sign any documents requested by the Plan including but not limited to reimbursement and/or subrogation agreements as the Plan or its agent(s) may request. Also, the Team Member or covered person agrees to furnish any other information as may be requested by the Plan or its agent(s). Failure or refusal to execute such agreements or furnish information does not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement. Any settlement or recovery received shall first be deemed for reimbursement of medical expenses paid by the Plan. Any excess after 100% reimbursement of the Plan may be divided up between the Team Member or covered person and their attorney if applicable. If any provision is made for future medical expenses in the settlement or recovery, accident related claims made after satisfaction of this obligation shall be paid by the Team Member or covered person and not the plan.

The Team Member or covered person agrees to take no action that in any way prejudices the rights of the Plan. If it becomes necessary for the Plan to enforce this provision by initiating any action against the Team Member or covered person, then the Team Member or covered person agrees to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome.

The Plan Administrator has sole discretion to interpret the terms of this provision in its entirety and reserves the right to make changes as it deems necessary.

If the Team Member or covered person takes no action to recover money from any source, then the Team Member or covered person agrees to allow the Plan to initiate its own direct action for reimbursement.

HONOR OF STATE SUBROGATION RIGHTS

Notwithstanding any other provision of this Plan to the contrary, the Plan will honor any subrogation rights that a State may have gained from a Medicare eligible beneficiary covered by the Plan by virtue of the State's having paid Medicare benefits, provided that the Plan has a legal liability for coverage.

PRIVACY

In administering your Plan benefits, the Claims Administrator will comply with all applicable privacy and access statutes, rules and regulations.

EMPLOYEE RETIREMENT INCOME SECURITY ACT
(ERISA) RIGHTS

As a participant of this Employee Benefit Plan, an employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as amended (hereinafter referred to as ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine without charge, at the Plan Administrator's office or the benefit administrator's office, and at other locations, during normal business hours, all Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as annual reports, and Form 5500, as may be applicable.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for copies, unless prohibited by law.
- 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 financial report, if such summary financial report is required to be completed by the Plan.
- File suit in federal court, if any materials requested are not received within 30 days of the participant's request, unless the materials were not sent because of matters beyond the control of the Administrator. The court may require the Plan Administrator to pay up to $110.00 for each day's delay until the materials are received.

In addition to creating rights for Plan participants, ERISA imposes obligations upon the persons who are responsible for the operation of the Employee Benefit Plan. Additionally, issues involving Qualified Medical Child Support Orders (QMCSO) may be resolved in Federal court.

The persons are referred to as "fiduciaries" in the law. Fiduciaries must act solely in the interest of the Plan participants and they must exercise prudence in the performance of the Plan duties. Any fiduciary who violates ERISA may be removed and required to make good any losses he has caused the Plan.

An employer may not fire or discriminate against an employee to prevent him from obtaining a benefit or exercising his rights under ERISA.

If an employee is improperly denied a benefit in full or in part, the employee must exhaust the appeals process as defined in this Plan before he has a right to file suit in federal or state court. If Plan fiduciaries are misusing the Plan's money, an employee has a right to file suit in federal court or request assistance from the U.S. Department of Labor. If he is successful in his lawsuit, the court may, if it so decides, require the other party to pay his legal costs, including attorney's fees. If the employee is unsuccessful, the court may, if it so decides, order him to pay these costs and fees, if, for example, it finds his claim to be frivolous.

The employer is the named fiduciary of the Plan within the meaning of Section 401(a)(1) of ERISA. The employer shall exercise all discretionary authority and control with respect to

management of the Plan which is not specifically granted to the Benefits Administrator or a fiduciary.

The employer may delegate certain other fiduciary responsibilities under the Plan to persons who are not named fiduciaries of the Plan. If the employer delegates its fiduciary responsibilities to another person, except as otherwise required by ERISA, the delegation shall be made in writing by the employer and a copy of the delegation will be kept with the records of the Plan.

Each fiduciary is solely responsible for his/her own acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all the responsibilities imposed upon the other fiduciary by law. No fiduciary shall have any liability for a breach of fiduciary responsibility by another fiduciary with respect to the Plan unless it participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach, fails to take responsibility or immediate action to remedy such breach, or, through its negligence in performing its own specific fiduciary responsibilities which give rise to its status as a fiduciary, it enables such other fiduciary to commit a breach of the latter's fiduciary responsibility.

No fiduciary is liable for a breach of fiduciary duty committed before it became a fiduciary and nothing in the Plan shall relieve any person from liability for his or her own misconduct or fraud.

IF YOU HAVE ANY QUESTIONS ABOUT THIS STATEMENT OR ABOUT YOUR RIGHTS UNDER ERISA, 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 INQUIRIES, EMPLOYEE BENEFITS SECURITY ADMINISTRATION, U.S. DEPARTMENT OF LABOR, 200 CONSTITUTION AVENUE NW, WASHINGTON, DC 20210.

DEFINITIONS FOR THE PURPOSE OF THIS PLAN

ACCIDENT: Sudden and unexpected injury to the body caused by an external force. Lifting, bending, stooping, simple exertion, etc., are not, in themselves, accidental events.

ADVERSE BENEFIT DETERMINATION: The appeals procedures are triggered by an adverse benefit determination. An adverse benefit determination is a denial, reduction or termination of, or a failure to provide, or make payment (in whole or in part) for a benefit. This includes any such denial, reduction, termination, or failure to provide or make payment that is based on:

- A determination of eligibility to participate in the Plan; or
- A rescission of coverage; or
- A benefit resulting from the application of any utilization review; or
- Failure to cover an item or service for which Benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or medically appropriate.

AGENT FOR SERVICE OF LEGAL PROCESS: Legal process may be served on the Plan Administrator at the address indicated in the chapter, GENERAL PLAN INFORMATION.

ALTERNATE FACILITY: A health care facility that is not a hospital, or a facility that is attached to a hospital and that is designated by the hospital as an alternate facility. This facility provides one or more of the following services on an outpatient basis, as permitted by law:

- Pre-scheduled surgical services.
- Emergency health services.
- Urgent care services.
- Pre-scheduled rehabilitative, laboratory or diagnostic services.
- Behavioral health services on an outpatient or inpatient basis.

AMENDMENT: A formal document that changes the provision of this Plan that is adopted through a formal resolution by the employer through its governing body or authorized executive.

The employer may amend this Plan at any time and will provide written notice to participants. Summary of Material Modifications (SMM) must be distributed within 60 days after a material reduction in benefits has been adopted. Plan Amendments can be made retroactive to the extent permitted by law.

ANCILLARY CHARGE: A charge, in addition to the Co-pay or coinsurance amount, that you are required to pay when a brand name drug is dispensed at your or the health care provider's request, when a chemically equivalent generic drug is available. The ancillary charge is calculated as the difference between the brand name drug price for network pharmacies and the prescription drug cost or MAC list price of the chemically equivalent generic drug.

APPLIED BEHAVIOR ANALYSIS: Means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

ASSIGNMENT OF BENEFITS: Assignment of Benefits occurs when you file a claim and authorize the Plan to pay your doctor or hospital directly.

AUTHORIZED REPRESENTATIVE: A claimant may act through an authorized representative. The Department of Labor (DOL) has clarified that it is reasonable to require written authorization signed by the Plan participant or beneficiary, on a form specified by the Plan for an authorized representative to act on behalf of the Plan participant or beneficiary in connection with non-urgent and post-service claims. However, if an urgent care claim is involved, a health care professional evidencing knowledge of a claimant's medical condition will have to be accepted as sufficient to establish authorized representative status. According to the DOL, a medical service provider does not become an authorized representative within the meaning of the regulations as a result of an assignment of benefits by a plan participant or beneficiary.

The claimant has the right to revoke the assignment of an authorized representative at any time.

AUTISM DIAGNOSTIC OBSERVATION SCHEDULE: Means the protocol available through Western psychological services for diagnosing and assessing Autism Spectrum Disorders or any other standardized diagnostic measure for Autism Spectrum Disorders that is approved by the Director of the Department of Insurance and Financial Services, if the Director determines that the diagnostic measure is recognized by the health care industry and is an evidence-based diagnostic tool.

AUTISM SPECTRUM DISORDERS: Means any of the following pervasive developmental disorders as defined by the Diagnostic and Statistical manual:

- Autistic disorder
- Asperger's Disorder
- Pervasive developmental disorder not otherwise specified.

AUTISM TREATMENT PLAN: Means a written, comprehensive, and individualized intervention plan that incorporates specific treatment goals and objectives and that is developed by a board certified or licensed in-network provider who has the appropriate credentials and who is operating within his or her scope of practice, when the treatment of an Autism Spectrum Disorder is first prescribed or ordered by a licensed physician or licensed psychologist.

BEHAVIORAL ANALYST: a board-certified therapist who directly supervises and is responsible for acquiring, training, and overseeing the work of lay workers who deliver the intensive behavioral/educational interventions.

BEHAVIORAL HEALTH SERVICES: Services for the diagnosis and treatment of mental illnesses, alcoholism and substance use disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a condition or disorder is listed in the current Diagnostic

and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is covered under this Plan.

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

BRAND GENERIC DIFFERENCE. A charge, in addition to the Copayment or Coinsurance amount, that you are required to pay when a Brand-Name Prescription Drug Product is dispensed at your or the health care provider's request, when a chemically equivalent Generic Prescription Drug Product is available.

The Brand Generic Difference is calculated as the difference between the Brand-Name Prescription Drug Product price for Network Pharmacies and the Prescription Drug Cost or MAC list price of the chemically equivalent Generic Prescription Drug Product.

BUSINESS ASSOCIATE (BA): A person or organization that performs a function or activity on behalf of a covered entity, but is not part of the covered entity's workforce. A business associate can also be a covered entity in its own right.

CALENDAR YEAR: For purposes of this Plan, a length of time beginning January 1 and ending December 31.

CHILD: Your natural child, adopted child, child placed for adoption, stepchild, or a child for whom you are the legal guardian and who resides with you. An "adopted child" or a "child placed for adoption" is any person under the age of 18 as of the date of adoption or placement for adoption. "Placed for adoption" means, in connection with adoption proceedings, the assumption and retention by a health plan participant or beneficiary of the legal duty for the total or partial support of a child to be adopted. The child's placement with such person terminates upon the termination of such legal obligation.

This Plan is intended to comply with the Omnibus Budget Reconciliation Act of 1993 with respect to dependent child eligibility and Qualified Medical Child Support Orders.

CLAIM: A claim is any request for a plan benefit or benefits, made by a claimant or by a representative of a claimant that complies with a Plan's reasonable procedure for making benefit claims. A request for benefits includes a request for coverage determination, for pre-authorization or approval of a plan benefit, or for a utilization review determination in accordance with the terms of the Plan.

Requests for determinations of eligibility under the Plan are not required to be treated as claims for benefits for purposes of ERISA's claim procedure. However, where a claim for benefits is made and the claim is denied because the claimant is not eligible for benefits under the terms of the Plan, the claimant shall be afforded the right to appeal that determination in accordance with the claims procedures outlined in the Plan.

Under the terms of this Plan, a claim is not deemed to be a claim when there is a casual inquiry about benefits. For this Plan to consider a request for benefits as a claim, it is required that a claim for pre-service care, post-service care and concurrent care benefits

must be filed in writing or submitted electronically and must include applicable codes. Less stringent guidelines may apply in the case of an urgent care claim.

CLAIMS ADMINISTRATOR: The firm providing administrative services to the employer in connection with the operation of the Plan and performing certain functions, including underwriting, enrollment applications, maintaining current Plan data, billing, processing and payment of claims and providing the employer with any other information deemed necessary by the Third Party Administrator.

COINSURANCE: The charge, stated as a percentage of eligible expenses, that you are required to pay for certain covered health services.

COMPOUNDED MEDICATIONS: Those that are not commercially available, and the dispensing pharmacy must prepare them individually by combining, mixing, or altering ingredients or components. Compounded medications are considered Experimental or Investigational based on University of Michigan Health Service Company medical policy and nationally recognized guidelines because they have not been approved for general use by the Food and Drug Administration (FDA)

CONGENITAL ANOMALY: A physical developmental defect that is present at birth, and is identified within the first 12 months of birth.

CONSENT: Permitted disclosures allow a covered entity to disclose Protected Health Information (PHI) to the individual whose PHI is being disclosed and with consent of the individual for the purposes of treatment, payment or health care operations. Covered entities may use or disclose PHI with written authorization from plan participants. The claimant has the authority to revoke an authorized consent at any time.

CONTRACEPTION, CONTRACEPTIVE MEDICATIONS: A Prescription Drug Product that is used to prevent pregnancy from occurring in a woman.

CONTRACEPTIVE PRESCRIPTION DRUG LIST: A list that identifies those Contraceptive Prescription Drug Products for which Benefits are available with no member cost share under the Plan. This list is subject to our periodic review and modification. The current list may be accessed through the Internet at www.express-scripts.com or by calling the Customer Service number on your ID card.

COORDINATION OF BENEFITS: If an individual is covered by another benefit plan, this Plan will coordinate its payment of benefits with the other plan to allow as complete claim reimbursement as possible, within the coverage limits, without providing duplicate payments.

CO-PAY: The charge, stated as a set dollar amount, that you are required to pay for certain covered health services.

COSMETIC SURGERY: Any surgery or procedure that is not medically necessary, which changes physical appearance, the texture or appearance of the skin, the relative size or position of any part of the body, or which is intended to treat a mental health disorder or emotional condition through change in bodily form.

In compliance with the Women's Health and Cancer Rights Act of 1998 (WHCRA), reconstructive surgery of a breast following a mastectomy and surgery and reconstruction of the other breast to produce a symmetrical appearance are not considered cosmetic surgery.

COVERED ENTITY (CE): Under HIPAA, this is a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a HIPAA transaction.

COVERED HEALTH SERVICE(S): Those health services determined to be Medically Necessary per University of Michigan Health Service Company medical policy and nationally recognized guidelines. They are any of the following:

•Provided to prevent, diagnose, or treat a Sickness, Injury, mental illness, substance use disorder, or their symptoms.

•Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines.

•Not provided for the convenience of the Covered Person, Physician, facility, or any other person.

•Stated as covered in this Plan Document.

•Not stated as excluded in this Plan Document.

COVERED PERSON: The term “covered person” shall mean any eligible Team Member or eligible dependent(s) as defined in the chapter, ELIGIBILITY PROVISIONS.

CUSTODIAL CARE: This term means: (a) room and board and other institutional or nursing services which are provided for a person due to his or her age or mental or physical condition primarily to aid the person in daily living; or (b) services which are given merely as care to maintain the person’s present state of health and which cannot be expected to improve a medical condition to a great extent. Custodial care includes non-health related services, such as assistance in activities of daily living (including but not limed to feeding, dressing, bathing, transferring, and ambulating); or health-related services that do not seek to cure or that are provided during periods when the medical condition of the patient who requires the service is not changing; or services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

DAY: The term used in the regulations means calendar days, not business days. 65 Fed. Reg. 70248.n.9 (Nov. 21, 2000).

DENTIST: A person duly licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry in the locality where the service is rendered.

DESIGNATED FACILITY: A facility that has entered into an agreement on behalf of the facility and its affiliated staff with University of Michigan Health Service Company or with an organization contracting on behalf of University of Michigan Health Service Company to render covered health services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a hospital is an in-network hospital does not mean that it is a Designated Facility.

DISCLOSURE, ACCOUNTING OF: Under HIPAA this is a list of any entities that have received personally identifiable health care information for uses unrelated to treatment and payment.

DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) (to include minimum necessary scope): Release or divulgence of information by an entity to persons or organizations outside of that entity.

DURABLE MEDICAL EQUIPMENT: Medical equipment that is all the following: can withstand repeated use; is not disposable, is used to serve a medical purpose with respect to treatment of an injury or illness or their symptoms; is of use to a person only in the presence of a disease or physical disability; is appropriate for use in the home, and is not implantable within the body.

ELECTRONIC DATA INTERCHANGE (EDI): This usually means X12 and similar variable-length formats for the electronic exchange of structured data. It is sometimes used more broadly to mean any electronic exchange of formatted data.

ELECTRONIC PROTECTED HEALTH INFORMATION (ePHI): Protected health information, as defined by the Security Rule that is (i) transmitted by electronic media; or (ii) maintained in electronic media.

ELIGIBLE MEDICAL EXPENSE: The fee used to determine the amount paid for incurred charges while the Policy is in effect. University of Michigan Health Service Company determines the eligible expense as stated below:

When charges for eligible healthcare services are received from in-network providers, the eligible expense is our contracted fee(s) with that provider.

Eligible expense is determined solely in accordance with University of Michigan Health Service Company's reimbursement policy guidelines. We develop reimbursement policy guidelines, in University of Michigan Health Service Company'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.
- 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 we accept.

EMERGENT ILLNESS: Severe symptoms occurring suddenly and unexpectedly which could reasonably be expected to result in serious physical impairment or loss of life, or could seriously jeopardize a covered person's health if not treated immediately.

ERISA: ERISA is the Employee Retirement Income Security Act of 1974, as amended. As a participant in this Plan, you have a number of rights under ERISA as outlined in this Plan.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES: Medical, surgical, diagnostic, psychiatric, Substance Use Disorders Treatment, drugs, 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 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 that are federal FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.)
- Any service billed with a temporary procedure code.

This does not include any off-label usage of a Prescription Drug Product, provided that:

- The drug is approved by the FDA.
- The drug is prescribed by an allopathic or osteopathic Physician for the treatment of either of the following:
  - A life-threatening condition, so long as the drug is medically necessary to treat that condition and the drug is on the Prescription Drug List or accessible through our Prescription Drug List procedures.
  - A chronic and seriously debilitating condition, so long as the drug is Medically Necessary to treat that condition and the drug is on the Prescription Drug List or accessible through our Prescriptions Drug List procedures.
  - The drug has been recognized for treatment for the condition for which it is prescribed by one of the following:
    - The American Medical Association Drug Evaluations.
    - The American Hospital Formulary Service Drug Information.
    - The United States Pharmacopoeia Dispensing Information, Volume 1, Drug Information for the Health Care Professional.
    - Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective, unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

As used in this Exclusion:

- “Chronic and seriously debilitating” means a disease or condition that requires ongoing treatment to maintain remission or prevent deterioration and that causes significant long-term morbidity.
- “Life-threatening” means a disease or condition where the likelihood of death is high unless the course of the disease is interrupted or that has a potentially fatal outcome where the end point of clinical intervention is survival.
- “Off-label” means the use of a drug for clinical indications other than those stated in the labeling approved by the Food and Drug Administration.

If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment) we may determine that an Experimental or Investigational Service meets the definition of a Covered Health Service for that Sickness

or condition. For this to take place, we will consider using the criteria as described above or we may determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

FERTILITY TREATMENT: Such treatment to conceive a pregnancy includes in-vitro fertilization, artificial insemination, GIFT, or any other procedure designed to induce pregnancy, and fertility medications. Also, lab work, ultrasounds, and tests beyond the initial diagnosis of infertility.

FRAUD: Intentionally, or knowingly and willfully attempting to execute or participate in a scheme to falsely obtain unfair or unlawful financial or personal gain from any health care benefit program. Fraud may include, but is not limited to:

- Seeking reimbursement for services not rendered;
- Selling prescription drugs that were prescribed for you to someone else;
- Misrepresenting the date that a service was provided;
- Misrepresentation of services (e.g., misrepresenting who rendered the service, the condition or diagnosis of the patient, the charges involved, or the identity of the provider or recipient;
- Seeking reimbursement for excessive, inappropriate, or unnecessary testing or other services;
- Receiving kickbacks for making a referral or for receiving services related to the referral;
- Altering claim forms, electronic records, or medical documentation;
- Improper use of Plan identification card; or
- Providing false information or withholding accurate information related to eligibility for coverage under this Plan, including dependent eligibility.

FREESTANDING SURGICAL CENTER: A duly licensed institution or facility, either freestanding or as part of a hospital with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted and discharged from within a 24-hour period. This term may be used interchangeably with “ambulatory surgical center.”

FUNDING: Funds for payment of claims are paid into an Employee Benefit Account or Trust from which claims are paid. All funds received by the account or trust shall be applied toward payment of claims and reasonable expenses of administration of the Plan.

GENERIC: A Prescription Drug Product: (1) that is chemically equivalent to a Brand-Name drug; or (2) that we identify as a Generic product based on available data resources 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 us.

GENETIC INFORMATION: Information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that

identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

HEALTH AND HUMAN SERVICES (HHS): The Department of Health and Human Services. The federal government department that has primary responsibility for implementing HIPAA.

HEALTH CARE CLEARINGHOUSE: Under HIPAA, this is an entity that processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction, or that receives a standard transaction from another entity and processes or facilitates the processing of that information into nonstandard format or nonstandard data content for a receiving entity.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA): A federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives HHS the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191.

HOME HEALTH CARE AGENCY: A public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all the following conditions:

- It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services.
- It has policies established by a professional group associated with the agency or organization. This professional group must include at least one physician and at least one registered graduate nurse (R.N.) to govern the services provided and it must provide for full-time supervision of such services by a physician or registered graduate nurse.
- It maintains a complete medical record on each individual.
- It has a full-time administrator.

HOME HEALTH CARE SERVICES:

- Nursing care rendered in the covered person’s home by a home health aide, registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse under the supervision of a registered nurse (R.N.).
- Visits provided by a medical social worker (MSW).
- Physical, speech, or occupational therapy provided in the covered person’s home.

- Physical, speech, or occupational therapy or the use of medical equipment provided on an outpatient basis by a home health agency, a hospital, or other facility, if arranged by a home health agency.
- Ambulance to the patient's home from the hospital where the patient's condition mandates such utilization and the diagnosis makes automobile unsuitable. Verification of medical necessity must be made by the attending physician in order for this to be a covered expense.
- Medications and supplies which would have been provided in the hospital, but not including meals normally prepared in the home.
- Rental of durable medical equipment, or purchase if approved in advance.

HOSPICE: A coordinated plan of home and/or inpatient care that treats the terminally ill patient and family (you and your covered dependents) as a unit. The plan provides care to meet the special needs of the family unit during the final stages of a terminal illness and during bereavement. A team of trained medical personnel, homemakers, and counselors act under an independent hospice administration. The hospice administration must meet established standards, including any legal licensing requirements of the State or locality in which it operates.

HOSPITAL: A legally operated institution providing inpatient care and treatment through medical, diagnostic, and major surgical facilities on its premises, under supervision of a staff of doctors, and with 24-hour-a-day nursing services; and/or one accredited as a hospital by the Joint Commission on Accreditation of Hospitals; and/or a hospital, psychiatric hospital, or a tuberculosis hospital, as those terms are defined in Medicare, which is qualified to participate in and eligible to receive payments under and in accordance with the provisions of Medicare; and/or a substance use disorder or alcoholic treatment facility licensed and approved by the State in which the treatment was rendered. The term does not include a nursing home or an institution, or any part thereof, used mainly as a facility for convalescence, nursing, rest, or care of the aged.

HOSPITAL ADMISSION: Admission of a covered person to a hospital as an inpatient for medically necessary care and treatment of an illness or injury.

IMMEDIATE FAMILY MEMBER: A person who is related to the claimant as a spouse, parent, grandparent, aunt, uncle, child, brother or sister, whether the relationship is by blood or exists in law.

INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI): Is information that is a subset of health information, including demographic information collected from an individual, and:

- Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
- Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
  - That identifies the individual; or

- With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

INJURY AND ILLNESS: The term “injury” shall mean accidental or self-inflicted bodily injury. All injuries sustained by a covered person in connection with any one incident shall be considered one injury.

The term “illness” shall include illness, mental, emotional, or nervous disorders, and pregnancy and complications thereof.

No benefits will be payable for expenses arising out of occupational injuries and illnesses which are compensable under a Worker’s Compensation insurance program.

INPATIENT: A person receiving room and board while undergoing treatment in a hospital or treatment facility.

INPATIENT STAY: An uninterrupted confinement, following formal admission to a hospital, skilled nursing facility or inpatient rehabilitation facility.

INTENSIVE CARE UNIT: A section, ward, or wing within the hospital which is distinguishable from the other hospital facilities because it:

- Is operated solely for the purpose of providing room and board and professional care and treatment for critically ill patients, including constant observation and care by a registered professional nurse (R.N.) or other highly-trained hospital personnel; and
- Has special supplies and equipment necessary for such care and treatment, available on a standby basis for immediate use.

This term shall not include any hospital facility maintained for the purpose of providing normal postoperative recovery or service, but shall include cardiac care and burn units.

LIFETIME: For purposes of this Plan, lifetime shall mean while covered under this self-funded Plan.

MEDICAL EXPENSE BENEFIT: A benefit that covers certain expenses for illness, injury, or pregnancy in a calendar year.

MEDICALLY NECESSARY – Health care services and supplies, which are determined by us to be medically appropriate per University of Michigan Health Service Company medical policy and nationally recognized guidelines, and

- Not experimental or investigational services; and
- Necessary to meet the basic health needs of the covered person; and
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered health service; and
- Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research or health care coverage organizations or governmental agencies that are accepted by us; and
- Consistent with the diagnosis of the condition; and
- Required for reasons other than the convenience of the covered person or his/her physician; and

- Demonstrated through prevailing peer-reviewed medical literature to be either:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed, or,
  - Safe with promising efficacy:
  - For treating a life-threatening sickness or condition; and
  - In a clinically controlled research setting; and
  - Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For purposes of this definition, the term “life threatening” is used to describe sickness or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a physician has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for an injury, sickness, or mental illness, or the fact that the physician has determined that a particular health care service or supply is medically necessary or medically appropriate does not mean that the procedure or treatment is a covered health service under the Policy. The definition of medically necessary used in this Summary Plan Description relates only to benefits and may differ from the way in which a physician engaged in the practice of medicine may define medically necessary.

MEDICARE: The programs established by Title 1 of Public Law 89-97 (79 Statutes 291) as amended, and entitled Health Insurance for the Aged Act and which includes Parts A, B, C and D.

MENTAL HEALTH DISORDERS: Conditions submitted for reimbursement with diagnosis codes, including but not limited to, those which are listed as “mental disorders” (290.0-319) in the International Classification of Diseases, ICD-10, or as amended.

MINIMUM NECESSARY REQUIREMENT: Whenever using or disclosing PHI reasonable efforts to limit the PHI used or disclosed to the minimum necessary to accomplish the intended purpose of the use or disclosure must be maintained.

MOTOR VEHICLE: A vehicle, including a trailer, operated, or designed for operation upon a public highway by power other than muscular which has at least two wheels. Motor vehicle does not include a farm tractor or other implement of husbandry that is not subject to the registration requirements of the Michigan Vehicle Code.

NAMED FIDUCIARY: The employer is the named fiduciary of the Plan within the meaning of Section 401(a)(1) of ERISA. The employer shall exercise all discretionary authority and control with respect to management of the Plan that is not specifically granted to the Claims Administrator or any fiduciary.

The employer may delegate certain of its fiduciary responsibilities under the Plan to persons who are not named fiduciaries of the Plan. If the employer delegates its fiduciary responsibilities to another person, except as otherwise required by ERISA, the delegation shall be made in writing by the employer, and a copy of the delegation will be kept with the records of the Plan.

Each fiduciary is solely responsible for its own acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all the responsibilities imposed upon the other fiduciary by law. No fiduciary shall have any liability for a breach of fiduciary responsibility by another fiduciary with respect to the Plan unless it participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach, fails to take responsible remedial action to remedy such breach or, through its negligence in performing its own specific fiduciary responsibilities which give rise to its status as a fiduciary, it enables such other fiduciary to commit a breach of the latter's fiduciary responsibility.

No fiduciary is liable for a breach of fiduciary duty committed before it became a fiduciary and nothing in the Plan shall relieve any person from liability for his or her own misconduct or fraud.

NETWORK PHARMACY: A pharmacy that:

- Has entered into an agreement with us or our designee to provide Prescription Drug Products to Covered Persons.
- Has agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Has been designated by us as a Network Pharmacy.
- Is either a retail or a mail-order 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 federal FDA, and ending on the earlier of the following dates:

- The date it is assigned to a tier by our P&T Committee.
- December 31st of the following calendar year.

NO-FAULT MOTOR VEHICLE PLAN: A compulsory motor vehicle plan that may provide payments for medical, dental care, or wage loss which are payable, in whole or in part, without regard to fault.

NON-PREFERRED BRAND-NAME: Covered Brand-Name drugs on Tier 3 for which there is either a Generic alternative, or a more cost-effective, Preferred Brand-Name drug available on a lower tier. This tier does not include Specialty Drugs.

NON-PREFERRED SPECIALTY: Covered Specialty Drugs on Tier 5 that include Non-Preferred Specialty Drugs used to treat various health conditions at the highest cost share to you. There may be either Generic drugs, Preferred Brand-Name drugs, or Preferred Specialty Drugs available.

NURSE: A licensed registered nurse (RN) or a licensed practical nurse (LPN).

OBSERVATION CARE: A well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to the Emergency Department and who then

require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge.

OCCUPATIONAL THERAPY: Treatment of injury or illness other than learning disabilities or developmental delays (except for covered services for Autism Spectrum Disorders), to prevent disability or to restore a disabled person to healthy, social, or economic independence. Such therapy includes programs to restore or develop the patient's self-care, work, or leisure time skills, however, does not include therapy that is a recreational program. Eligible services must be ordered by a physician for the necessary treatment of a patient's condition, and be provided by a registered occupational therapist.

OPTICIAN: A person licensed to translate, fill, and adapt ophthalmic prescriptions, products, and accessories.

OPTOMETRIST: A person licensed to measure the powers of vision and adapt lenses or prisms for the aid thereof, utilizing any means other than drugs.

OUTPATIENT: A patient who comes to a hospital, clinic, doctor's office, or treatment facility for diagnosis and/or treatment, but does not occupy a bed or stay overnight.

PHARMACY: A licensed establishment where prescriptions are filled by a pharmacist licensed under the laws of the State or jurisdiction where he or she is practicing.

PHARMACY AND THERAPEUTICS ("P&T") COMMITTEE: Maintains a Prescription Drug List (PDL) to provide high quality, therapeutically appropriate drugs for use in treating the needs of our members. The P&T Committee regularly reviews new and existing medications to ensure the formulary remains responsive to the needs of our members and community providers. The following factors are considered by the P&T Committee when determining tier placement of medication on the formulary (there may be other factors not listed): safety and efficacy; therapeutic advantages/limitations relative to similar medications currently available; side effects that are different from others in its therapeutic class; and impact on total health care cost and patient clinical outcomes. In addition, the P&T Committee maintains pharmacy-related medical benefit determination policies that promote safety, effectiveness, and affordability of medications, as well as, reviews utilization management clinical rules including step therapy, quantity limits, quantity duration limits and age edits.

PHYSICAL THERAPY: The use of physical agents in the recovery of bodily function after injury or disease other than learning disabilities or developmental delays (except for covered services for Autism Spectrum Disorders). Such physical agents include massage, heat hydrotherapy, electricity and exercise. Physical therapy must be ordered by a physician and provided by a licensed physical therapist.

PHYSICIAN OR OTHER LICENSED OR CERTIFIED PROVIDERS: Means a duly licensed Doctor of Medicine (M.D.), osteopath (D.O.), podiatrist (D.P.M.), chiropractor (D.C.), fully licensed psychologist (Ph.D.) or psychiatrist, or any other provider rendering a covered service, acting within the scope of his license who is required to be recognized as such by an applicable State code.

PLAN: Your Health and Welfare benefits. This document is your Summary Plan Description.

PLAN ADMINISTRATOR, AND PLAN ADMINISTRATION: The employer is the Plan Administrator of the Plan. As Plan Administrator, the company must supply you with this document and other information and file various reports and documents with government agencies. In its role of administering the Plan, the Plan Administrator also may make rulings, interpret the Plan, prescribe procedures, gather needed information, receive and review financial information regarding the Plan, employ or appoint individuals to assist in any administrative function, and generally do all other things needed to administer the Plan.

The Plan Administrator has all powers and authority needed to enable it to carry out its duties under the Plan, including by way of illustration and not limitation (a) the power and authority contemplated by the Employee Retirement Income Security Act of 1974 (ERISA), as amended, with respect to the Plan, and (b) the power and authority to make regulations with respect to the Plan not inconsistent with the terms of the Plan or ERISA (where applicable) and to determine, consistent with those regulations all the status and rights of participants, beneficiaries and other persons.

Failure by the Plan or Plan Administrator to insist upon compliance with any provisions of the plan at any time or under any set of circumstances shall not operate to waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are or are not the same. No waiver of any term or condition of the Plan shall be valid unless contained in a written memorandum expressing the waiver and signed by a person authorized by the Plan Administrator to sign the waiver.

The Plan Administrator shall interpret the Plan under Federal law, including ERISA.

PLAN DOCUMENT: The legal document according to which the Plan is administered.

PLAN MODIFICATION: The Plan may be modified or amended by the employer from time to time. Modifications that affect covered participants will be communicated to the Plan participants.

PLAN SPONSOR: The Employee Retirement Income Security Act of 1974 (ERISA) defines Plan Sponsor as (i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustee, or other similar group of representatives of the parties who establish or maintain the plan. The right is reserved in the Plan for the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan and any or all benefits provided under the Plan, covering any active employee or current or future retiree or dependent in whole or in part at any time. Any such change or termination in benefits will be based solely on the decision of the Plan Sponsor and may apply to all eligible active and non-active employees and dependents as either separate groups or as one group, regardless of status.

PLAN YEAR: A period commencing with the effective date of this Plan or a Plan anniversary and terminating the day before the next succeeding Plan anniversary date.

PREFERRED BRAND-NAME: Covered Single Source Brand-Name drugs on Tier 2 that have a proven record for safety and effectiveness. These drugs generally are more

expensive than Generic drugs. Generic drug alternatives may be available, offering more cost-effective therapies. This tier does not include Specialty Drugs.

PREFERRED SPECIALTY: Covered Generic or Single Source Brand-Name Specialty Drugs on Tier 4 that have a proven record for safety, clinical effectiveness, and cost efficacy.

PREFERRED TOBACCO CESSATION PRODUCTS: A select list of prescription and over-the-counter drugs that are covered under the outpatient prescription drug plan for the treatment of tobacco dependence or addiction.

PREGNANCY: The term “pregnancy” and any conditions relating to pregnancy will be considered an illness. Pregnancy includes prenatal care, postnatal care, childbirth, and any complications associated with pregnancy.

PRESCRIPTION DRUG LIST: A list that identifies those Prescription Drug Products for which benefits are available under the Plan. This list is subject to our periodic review and modification. You may determine to which tier a particular prescription drug product has been assigned through the Plan’s website or by calling the Customer Service number on your ID card.

PRESCRIPTION DRUG PRODUCT: A medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill. A prescription drug product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled Team Member. For the purpose of Benefits under the Plan, this definition includes but is not limited to:

- 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;
  - Control solutions and combo kits;
  - Glucose monitors.

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 HEALTH SERVICES: Routine or screening covered services that are designated to keep you in good health and to prevent unnecessary injury, sickness, or disability, including but not limited to the following as may be appropriate based on your age and/or gender:

- Evidence-based items or services with an “A” or “B” rating from the U.S. Preventive Services Task Force (USPSTF), including breast cancer screening, mammography, and prevention;
- Immunizations for routine use in children, adolescents, and adults with a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Evidence-informed preventive care screenings for infants, children and adolescents provided in guidelines supported by the Health Resources and Services Administration (HRSA); and
- Evidence-informed preventive care and screening for women provided in guidelines supported by HRSA and not otherwise addressed by the USPSTF.
- Current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention.

The complete list of recommendations and guidelines can be found at http://www.HealthCare.gov/center/regulations/prevention.html (the “List”) and is continually updated to reflect both new recommendations and guidelines and revised or removed guidelines.

PROTECTED HEALTH INFORMATION (PHI): Individually Identifiable Health Information

- Except as provided in paragraph (2) of this definition, that is:
  - Transmitted by electronic media;
  - Maintained in any medium described in the definition of electronic media; or
  - Transmitted or maintained in any other form or medium.
- Protected Health Information excludes Individually Identifiable Health Information in:
  - Education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. 1232g; and
  - Records described at 20 U.S.C. 1232g(a)(4)(B)(iv).

QUALIFIED MEDICAL CHILD SUPPORT ORDER (“QMCSO”): The Plan Administrator shall adhere to the terms of any medical child support order that satisfies the requirements of this Section and Section 609 of ERISA. A medical child support order is any judgment, decree, or order (including a court approved property settlement agreement) issued by a court of competent jurisdiction which (a) Relates to the provision of child support with respect to the child of a participant under a group health plan (including this Plan) or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and related to medical benefits under the Plan, or (b) Enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13623 of the Omnibus Budget Reconciliation Act of 1993) with respect to the Plan, and which creates or recognizes the existence of an alternate recipient’s right to, or assigns to an alternate recipient the right to receive benefits payable with respect to a participant or beneficiary under the Plan. For purposes of this Section, an “alternate recipient” shall mean any child of a participant who

is recognized by a medical child support order as having a right to enrollment under this Plan with respect to the Participant.

A Qualified Medical Child Support Order must clearly specify: (a) The name and last known mailing address of the Participant and the name and mailing address of each alternate recipient covered by the order; (b) A reasonable description of the type of coverage to be provided under the Plan to each such alternate recipient, or the manner in which such type of coverage is to be determined; (c) The period to which such order applies; and (d) Each plan to which such order applies.

Any Qualified Medical Child Support Order shall not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13623 of the Omnibus Reconciliation Act of 1993).

The Plan Administrator shall promptly notify the Participant and each alternate recipient of the receipt of a medical child support order by the Plan and the Plan's procedures for determining the "qualified" status of medical child support orders, the Plan Administrator shall determine whether the order is a Qualified Medical Child Support Order and shall notify the Participant and each alternate recipient of this determination. If the Participant or any affected alternate recipient disagrees with the determinations of the Plan Administrator, the disagreeing party shall be treated as a claimant and the claims procedure of the Plan shall be followed. The Plan Administrator may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the Plan.

Alternate recipients of a Qualified Medical Child Support Order shall be treated as beneficiaries under the Plan for all purposes of ERISA.

Payments under this plan pursuant to a Qualified Medical Child Support Order in reimbursement for expenses paid by the alternate recipient or the alternate recipient's custodial parent or legal guardian shall be made to the alternate recipient or the alternate recipient's custodial parent or legal guardian.

REASONABLE AND CUSTOMARY CHARGE: A reasonable and customary ("R&C") charge shall be the usual charge made by a physician or supplier of services, medicines, or supplies and shall not exceed the general level of charges made by others rendering or furnishing such services, medicines, or supplies within the area in which the charge is incurred for the illness or injury being treated. The term "area" as it would apply to any particular service, medicine, or supply means a county or such greater areas as is necessary to obtain a representative cross section of the level of charges.

RECONSTRUCTIVE SURGERY: Any surgery or procedure which repairs or restores the damage, disfigurement, injury, malformation, or defect resulting from an accident, disease, infection, prior surgery, congenital anomaly or birth defect.

RECREATIONAL THERAPY: Outpatient or inpatient (provided during an inpatient stay) recreational activities that may be considered to serve a therapeutic purpose including, but not limited to, camp or camping events, sports or sporting events, horseback riding, art therapy services or art instruction, music therapy services or music instruction, boating or other recreational activities.

RESCISSION: A cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuation of coverage is *not* a rescission if the cancellation or discontinuance of coverage has a prospective effect. Rescission is allowed if it is due to:

- Failure to timely pay required premiums or contributions toward the cost of coverage;
- Fraud or intentional misrepresentation of a material fact;
- Failure to notify Plan Administrator of a divorce, resulting in the ex-spouse no longer being eligible for coverage.

RESIDENTIAL TREATMENT PROGRAM: Treatment for mental health conditions and substance use disorders, which does not meet the definition of inpatient Hospital care, but requires a patient to reside at a certified or licensed residential treatment facility for the duration of the treatment period. Treatment programs are designed to treat groups of patients with similar mental health conditions or substance use disorders, living within a supportive 24-hour community (e.g., a 28-day alcohol rehabilitation program).

ROUTINE PHYSICAL EXAM: Medical treatment, services or supplies, rendered solely for the purpose of health maintenance and not for the treatment of an illness or injury.

SECURITY RULE: The HIPAA regulations that are codified at 45 C.F.R. § 160 and 45 C.F.R. § 164, as amended from time to time.

SEMI-PRIVATE ACCOMMODATION: The term “semi-private” refers to a class of accommodations in a hospital or convalescent nursing facility in which at least two patient beds are available per room.

SICKNESS: Physical illness, disease, or Pregnancy. The term Sickness as used in the Plan Document does not include mental illness or substance use disorders, regardless of the cause or origin of the mental illness or substance use disorder.

SKILLED NURSING FACILITY: An institution that provides room and board and skilled nursing services for medical care. It must have (a) one or more licensed nurses on duty at all times supervised on a 24-hour basis by a registered nurse (R.N.) or a doctor; and (b) the services of a doctor available at all times by an established agreement.

It must also comply with the legal requirements that apply to its operation, and keep daily medical records on all patients.

This term does not include an institution, or any part thereof, used mainly for: (a) rest care; (b) care of the aged; (c) care of drug addicts or alcoholics; (d) custodial care; or (e) educational care.

SOUND, NATURAL TOOTH: A tooth that is whole or properly restored and is without impairment, periodontal or other conditions and which is not in need of treatment for any reason other than an accidental injury.

SPARROW PROVIDER NETWORK: The “Point of Service” benefit program and provider network selected for the provision of health care services to covered persons under the University of Michigan Health-Sparrow Medical Plan.

SPECIALTY DRUGS. Specialty Drugs are usually more expensive prescription medications used to treat complex, chronic conditions like cancer, rheumatoid arthritis and multiple sclerosis. Specialty Drugs often require special handling (like refrigeration during

shipping) and administration (such as injection or infusion). Patients using a Specialty Drug often must be monitored closely to determine if the therapy is working and to watch for side effects. Drugs on the Specialty Medication List are regularly reviewed and changed as needed.

Covered Persons may be directed to the site of care for administration of specific Specialty Drugs that is most cost-effective, clinically appropriate and/or can be safely administered such as a Physician's office or through home infusion services. Specialty Drugs may require prior authorization.

SPEECH THERAPY: Treatment by a qualified speech therapist to restore speech loss, or correct an impairment (except voice modulation or lisp), due to (a) a congenital defect for which corrective surgery has been performed, or (b) an injury or illness except a mental illness, psychoneurotic or personality disorders, learning disabilities or developmental delays (except for covered services for Autism Spectrum Disorders). Speech therapy must be ordered by a physician and provided by a licensed speech therapist.

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

SPOUSE: The person who is legally married to you while you are covered under this Plan. Specifically excluded from this definition is a spouse by reason of common law marriage.

SUBSTANCE USE DISORDER: The taking of alcohol or other drugs in quantities that place a person in potential hazard, or to the extent of loss of self-control or while habitually under the influence of alcohol or other drugs, endangers public health, safety or welfare.

SUMMARY HEALTH INFORMATION: Information, that may be Individually Identifiable Health Information, and:

- That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and
- From which the information described at §164.514(b)(2)(i) has been deleted except that the geographic information described in §164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

TEAM MEMBER: The word "Team Member" as used herein, shall mean any person employed and compensated for services by the employer as defined in the chapter, ELIGIBILITY PROVISIONS.

TEMPOROMANDIBULAR JOINT DYSFUNCTION: A malfunction of the joint formed by the lower jawbone and the temporal bone.

TERMINALLY ILL PATIENT: This term means a member of your family unit with a life expectancy of six months or less as certified in writing by the attending physician.

TOTAL DISABILITY: A Team Member is considered totally disabled if they are unable to perform each and every duty of their regular job for the period of disability as defined by this Plan. A Team Member is no longer considered totally disabled if they are or become qualified for any gainful occupation by education, training, or experience.

A dependent child is considered totally disabled if they are not able to perform the normal activities of a person of like age and sex in good health. A dependent child is no longer considered totally disabled if the child is able to perform the normal activities of a person of like age and sex in good health.

TPO (TREATMENT – PAYMENT – HEALTH CARE OPERATIONS):

- **TREATMENT** - Means the provision, coordination or management of health care and related services by one or more health care providers, including the coordination and management of health care by a provider and a third party, consultation between health care providers relating to a patient or the referral of a patient for health care from one provider to another.
- **PAYMENT** - Means activities undertaken by a health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provisions of benefits including but not limited to: determination of eligibility or coverage; adjudication or subrogation of health benefit claims; billing; claims management; collection activities; related health care data processing; review of health care services with respect to medical necessity, coverage under the Plan, appropriateness of care, justification of charges; utilization review activities, including pre-authorization, concurrent and retrospective review.
- Health Care **OPERATIONS** cover a wide range of activities including:
  - Quality assessments and improvement activities, case management, protocol development, and contacting providers about alternative treatments and related functions that do not include treatment.
  - Reviewing competence or qualification of health care professionals, evaluating provider or health plans performance, certification, licensing, or credentialing activities.
  - Underwriting, premium rating and other activities relating to the creation, renewal or placement of health insurance or health benefits – ceding, securing or placing a contract of reinsurance or stop-loss insurance; providing that if a health plan receives phi for such purposes and the insurance is not placed, the health plan may not use or disclose the PHI received for any other purpose, except as may be required by law.
  - Conducting or arranging for medical review, legal services or auditing function including fraud and abuse.
  - Business planning or development such as cost management, development or improvement in payment methods or policy coverages.
  - Business management and general administrative activities of the covered entity including customer service, resolution of internal grievances, due diligence in connection with a business transaction if the potential successor is or will become a covered entity.

TRICARE: The Civilian Health and Medical Program of the Uniformed Services formerly known as CHAMPUS.

UNPROVEN SERVICES: Services, including medications that are not consistent with conclusions of prevailing medical research, which demonstrate that the health service has

a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs:

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we and the Claims Administrator may determine that an Unproven Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we and the Claims Administrator must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

URGENT CARE CENTER: A facility that is engaged primarily in providing minor emergency and episodic medical care to a covered person. A board-certified physician, a registered nurse and a registered x-ray technician must be in attendance at all times that the clinic is open. The clinic's facilities must include x-ray and laboratory equipment and a life support system. For the purposes of this Plan, a clinic meeting these requirements will be considered an urgent care center, by whatever actual name it may be called. The term "urgent care center" may be used interchangeably with the term "minor emergency medical clinic."

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.

WELL BABY/WELL CHILD CARE: Medical treatment, services or supplies rendered to a child or infant solely for the purpose of health maintenance and not for the treatment of an illness or injury.

WORKER'S COMPENSATION: A fund to which an employer contributes, which provides coverage regarding job-related injuries and illnesses.

YOU: The eligible covered Team Member.

NOTICES

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

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

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

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).

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