Summary Plan Description

City of Tampa
Choice Plus HRA City UHPD DHP Plan

Effective: January 1, 2022
Group Number: 730334

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SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance-Related and Addictive Disorders Administrator: (800) 918-8667;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740800, Atlanta, GA 30374-0800; and
- Online assistance: **www.myuhc.com**.

City of Tampa is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members. It includes summaries of:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

This SPD is designed to meet your information needs. It supersedes any previous printed or electronic SPD for this Plan.

City of Tampa intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice subject to any collective bargaining agreements between the Employer and various unions, if applicable. This SPD is not to be construed as a contract of or for employment.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. City of Tampa is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the Plan works. If you have questions contact City of Tampa at (813) 274-8041 or call the number on your ID card.

How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments at www.tampagov.net or request printed copies by contacting City of Tampa at (813)-274-8041.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- City of Tampa is also referred to as Group.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan;
- The factors that impact your cost for coverage;
- Instructions and timeframes for enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you are a regular full-time Employee, a person that retires from the City of Tampa, a part-time employee who has a full-time status for the purposes of health insurance coverage who is scheduled to work at least 30 hours per week, and any other part-time Employee who is eligible by other guidelines as determined by the City of Tampa.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- your Spouse (includes Domestic Partner), as defined in Section 14, *Glossary;*
- your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption, a child placed for foster care, or a child for whom you or your Spouse are the legal guardian;
- a child placed for foster care;
- a newborn child of an Enrolled Dependent. The newborn child may be covered from birth to 18 months of age;
- an unmarried child age 26 or over who is or becomes disabled and dependent upon you.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

In addition to the above eligibility criteria you or any covered Dependent over the age of 18 must have a Diabetes-related Condition in order to enroll in the Diabetes Health Plan.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. In addition, if you and your Spouse are both covered under the Plan, you may each be enrolled as an Employee or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*.

In the event that your Dependent meets the following requirements, extended coverage is available for that Dependent up to the age of 30. Contact City of Tampa at (813)-274-8041 for details. To be eligible for extended coverage, a Dependent must satisfy the following:

- is unmarried and does not have dependent of his or her own;
- is a resident of Florida or a Full-Time Student, and
- does not have coverage as a named subscriber, insured, enrollee or covered person under any other group, blanket or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

If such a Dependent's coverage is terminated after the end of the calendar year in which the Dependent reached age 26, the child is not eligible to be covered under the Plan unless the Dependent was continuously covered by Creditable Coverage without a gap in coverage of more than 63 days.

A child who is covered under extended coverage provisions set forth above ceases to be eligible as a Dependent on the last day of the calendar year following the child's attainment of the limiting age or when the child no longer meets the requirements.

Cost of Coverage

You and City of Tampa may share in the cost of the Plan. Your contribution amount depends on your classification, the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld - and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of City of Tampa's cost in covering a Domestic Partner may be imputed to the Employee as income. In addition, the share of the Employee's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions. This may also apply to your dependent children age 26 and over.

Your contributions are subject to review and City of Tampa reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling City of Tampa at (813)-274-8041 or logging onto www.tampagov.net

How to Enroll

To enroll, call City of Tampa at (813)-274-8041 or log onto www.tampagov.net within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following January 1.

Important
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child, placement for foster care, or other family status change, you must contact City of Tampa at (813)-274-8041 within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once City of Tampa receives your properly completed enrollment, coverage will begin on the first day of the month following the completion of one month of employment. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the first of the month following the date City of Tampa receives notice of your marriage, provided you notify City of Tampa within 31 days of your marriage. Coverage for Dependent children, except for newborns, acquired through, adoption, or placement for adoption, placement for foster care is effective the date of the family status change, provided you notify City of Tampa within 31 days of the birth, adoption, or placement.

For newborns, coverage begins at the moment of birth if the newborn is enrolled by you as described below. For newborns who are placed for adoption or foster care, coverage begins from the moment of birth if there is an agreement to place or adopt the newborn and the newborn is ultimately placed in the your home. For newborns, adopted children and children placed for foster care, no Premium will be charged for the first 31 days if written notice to enroll the new dependent is given within 31 days of the event. If you fail to enroll the new dependent within 31 days but do so within 63 days of the event, you will be required to pay an additional Premium from the date of birth or placement. If written notice is not given within 63 days of birth or placement, the newborn, foster child or adopted child may be enrolled during any Open Enrollment Period.

If You Are Hospitalized When Your Coverage Begins

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

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

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- registering a Domestic Partner;
- the birth, adoption, placement for adoption, or legal guardianship of a child;
- a change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (This is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- you or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact City of Tampa within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact City of Tampa within 60 days of determination of subsidy eligibility);
- a strike or lockout involving you or your Spouse; or
- a court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact City of Tampa within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Change in Family Status - Example

Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in City of Tampa's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under City of Tampa's medical plan outside of annual Open Enrollment.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Network and Non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Coinsurance; and
- Out-of-Pocket Maximum.

Accessing Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

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

You can choose to receive Designated Network Benefits, Network Benefits or non-Network Benefits.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Savings Program in Section 14, *Glossary*, of the SPD for details about how the Shared Savings Program applies.

Designated Network Benefits and Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Physician in order to obtain Network Benefits. In general health care terminology, a Primary Physician may also be referred to as a *Primary Care Physician* or *PCP*.

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

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

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

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

Covered Health Services provided at certain Network facilities by a non-Network Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section. For these Covered Health Services, "certain Network facility" is limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security* Act, and any other facility specified by the Secretary.

Air Ambulance transport provided by a non-Network provider will be reimbursed as set forth under Eligible Expenses as described at the end of this section.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits when Covered Health Services are received from a non-Network provider. In this situation, your Network Physician will notify UnitedHealthcare, and if UnitedHealthcare confirms that care is not available from a Network provider, UnitedHealthcare will work with you and your Network Physician to coordinate care through a non-Network provider.

Looking for a Network Provider?
In addition to other helpful information, **www.myuhc.com,** UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's

status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of City of Tampa or UnitedHealthcare.

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

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling UnitedHealthcare. A directory of providers is available online at **www.myuhc.com** or by calling the number on your ID card to request a copy. If you receive a Covered Health Service from a non-Network provider and were informed incorrectly prior to receipt of the Covered Health Service that the provider was a Network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for Network Benefits.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits. However, if you are currently receiving treatment for Covered Health Services from a provider whose network status changes from Network to non-Network during such treatment due to expiration or nonrenewal of the provider's contract, you may be eligible to request continued care from your current provider at the Network Benefit level for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact UnitedHealthcare at the number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Providers

If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Provider chosen by UnitedHealthcare. If you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct you to a Network provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Provider, UnitedHealthcare may reimburse certain travel expenses at UnitedHealthcare's discretion.

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

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

Limitations on Selection of Providers

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to provide and coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a single Network Physician for you. In the event that you do not use the selected Network Physician Covered Health Services will be paid as Non-Network Benefits.

Eligible Expenses

City of Tampa has delegated to the Claims Administrator the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount the Claims Administrator determines that the Plan will pay for Benefits.

- For Designated Network Benefits and Network Benefits for Covered Health Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Eligible Expenses and the amount the provider bills.
- For Non-Network Benefits, except as described below, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Eligible Expenses.
    - For Covered Health Services that are **Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians**, you are not responsible, and the non-Network provider may not bill

you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.

- For Covered Health Services that are **non-Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.
- For Covered Health Services that are **Emergency Health Services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.
- For Covered Health Services that are **Air Ambulance services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law, as described in the SPD.

Designated Network Benefits and Network Benefits

Eligible Expenses are based on the following:

- When Covered Health Services are received from a Designated Network and Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by the Claims Administrator, Eligible Expenses are an amount negotiated by the Claims Administrator or an amount permitted by law. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Non-Network Benefits

When Covered Health Services are received from a non-Network provider as described below, Eligible Expenses are determined as follows:

- For non-Emergency Covered Health Services received at certain Network facilities from non-Network Physicians when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act with respect to a visit as defined by the

Secretary, the Eligible Expense is based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by a state *All Payer Model Agreement*.
- The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
- The amount determined by *Independent Dispute Resolution (IDR)*.

For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act)*, a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act)*, an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service you are not responsible, and a non-Network Physician may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- For Emergency Health Services provided by a non-Network provider, the Eligible Expense is based on one of the following in the order listed below as applicable:

  - The reimbursement rate as determined by a state *All Payer Model Agreement*.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

  IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- **For Air Ambulance transportation provided by a non-Network provider,** the Eligible Expense is based on one of the following in the order listed below as applicable:

  - The reimbursement rate as determined by a state *All Payer Model Agreement*.
  - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
  - The amount determined by *Independent Dispute Resolution (IDR)*.

  IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

- When Covered Health Services are received from a non-Network provider, except as described above, Eligible Expenses are determined, based on one of the following:
  - Negotiated rates agreed to by the non-Network provider and either the Claims Administrator or one of the Claims Administrator's vendors, affiliates or subcontractors, at the Claims Administrator's discretion.
  - Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:
    - 50% of *CMS* for the same or similar freestanding laboratory service.
    - 45% of *CMS* for the same or similar Durable Medical Equipment from a freestanding supplier, or *CMS* competitive bid rates.
    - 70% of *CMS* for the same or similar physical therapy service from a freestanding provider.
  - When a rate is not published by *CMS* for the service, the Claims Administrator uses an available gap methodology to determine a rate for the service as follows:
    - For services other than Pharmaceutical Products, the Claims Administrator uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale or the amount typically accepted by a provider for the same or similar service. The relative value scale may be based on the difficulty, time, work, risk, location and resources of the service. If the relative value scale(s) currently in use become no longer available, the Claims Administrator will use a comparable scale(s). *UnitedHealthcare* and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to *UnitedHealthcare's* website at **www.myuhc.com** for information regarding the vendor that provides the applicable gap fill relative value scale information.
    - For Pharmaceutical Products, the Claims Administrator uses gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.
    - When a rate for a laboratory service is not published by CMS for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar Network providers for the same or similar service.
    - When a rate for all other services is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 20% of the provider's billed charge.

  The Claims Administrator updates the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically implemented within 30 to 90 days after *CMS* updates its data.

IMPORTANT NOTICE: non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here. This includes non-Ancillary Services when notice and consent is satisfied as described under section *2799B-2(d) of the Public Service Act*.

Don't Forget Your ID Card
Remember to show your UnitedHealthcare ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses, or the Recognized Amount when applicable, you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. There are separate Network and non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

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

Copayment

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

Enhanced Benefits
Members enrolled in this Plan qualify for a reduction or waiver of your Plan's Copay for certain medications commonly prescribed to people with a Diabetes-related Condition, as well as for Physician and Specialist office visits. For more information see *Physician's Office Services – Sickness and Injury* and *Enhanced Benefits* in Section 5, *Plan Highlights*.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services and after you meet the Annual Deductible.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There are separate Network and non-Network Out-of-Pocket Maximums for this Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual

maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Prescription Drugs*.

The following table identifies what does and does not apply toward your Network and non-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Copays, even those for Covered Health Services available in Section 15, *Prescription Drugs*	Yes	Yes
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not obtaining prior authorization as required	No	No
Charges that exceed Eligible Expenses, or the Recognized Amount when applicable.	No	No

SECTION 4 - PERSONAL HEALTH SUPPORT AND PRIOR AUTHORIZATION

What this section includes:

- An overview of the Personal Health Support program; and
- Covered Health Services for which you need to contact Personal Health Support.
- Covered Health Services which Require Prior Authorization.

Care Management

When you seek prior authorization as required, the Claims Administrator will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse, to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. When the Claims Administrator is called as required, they will work with you to implement the Personal Health Support process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. As of the publication of this SPD, the Personal Health Support program includes:

- **Admission counseling** - Personal Health Support Nurses are available to help you prepare for a successful surgical admission and recovery. Call the number on your ID card for support.
- **Inpatient care management** - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a

Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.

- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.
- **Cancer Management** - You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path.
- **Kidney Management** - You have the opportunity to engage with a nurse that specializes in kidney disease, education and guidance with CKD stage 4/5 or ESRD throughout your care path.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the toll-free number on your ID card.

Prior Authorization

UnitedHealthcare requires prior authorization for certain Covered Health Services. Network Primary Physicians and other Network providers are responsible for obtaining prior authorization before they provide these services to you.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers.

To obtain prior authorization, call the number on your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Contacting Personal Health Support is easy.
Simply call the number on your ID card.

Network providers are responsible for obtaining prior authorization from the Claims Administrator before they provide certain services to you.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization from the Claims Administrator before you receive these services. In many cases, your Non-Network Benefits will be reduced if the Claims Administrator has not provided prior authorization.

Services for which you are required to obtain prior authorization are identified in Section 6, *Additional Coverage Details,* within each Covered Health Service Benefit description. Please note that prior authorization timelines apply. Refer to the applicable Benefit description to determine how far in advance you must obtain prior authorization.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to notify Personal Health Support before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 10, *Coordination of Benefits (COB).*

SECTION 5 - PLAN HIGHLIGHTS

What this section includes:

- Payment Terms and Features.
- Schedule of Benefits.
- Enhanced Benefits.

City Plan with HRA with Diabetes Health Plan (DHP)

Payment Terms and Features

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Designated Network and Network	Non-Network
Copays In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages.		
■ Emergency Health Services	$300	$300
	Designated Network	
■ Physician's Office Services - Physician	$30	Not Applicable
■ Physician's Office Services - Specialist	$30	Not Applicable
	Network	
■ Physician's Office Services –Physician	$30	Not Applicable
■ Physician's Office Services - Specialist	$50	
■ Physician's Office Services for Allergy Injections	$5	Not Applicable
■ Urgent Care Center Services	$50	Not Applicable
■ Manipulative Treatment	$50	Not Applicable
Copays do not apply toward the Annual Deductible.		
Annual Deductible		

Plan Features	Designated Network and Network	Non-Network
■ Individual	$2,000	$4,000
■ Family (not to exceed the applicable Individual amount per Covered Person)		
Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible.	$4,000	$8,000
Annual Out-of-Pocket Maximum		
■ Individual	$4,000	$8,000
■ Family (not to exceed the applicable Individual amount per Covered Person)	$8,000	$16,000
The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.		
Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Out-of-Pocket Maximum.		
Lifetime Maximum Benefit	Unlimited	
There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.		
Generally the following are considered to be essential benefits under the *Patient Protection and Affordable Care Act*:		
Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance-related and addictive disorders services (including behavioral health treatment); prescription drug products; rehabilitative and habilitative services and devices; laboratory services; preventive and		

Plan Features	Designated Network and Network	Non-Network
wellness services and chronic disease management; and pediatric services, including oral and vision care.		

Schedule of Benefits

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on *Eligible Expenses* or, for specific Covered Health Services as described in the definition of Recognized Amount in Section 14, *Glossary*.

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated Network and Network	**Non-Network**
Ambulance Services ■ Emergency Ambulance ■ Non-Emergency Ambulance Eligible Expenses for Air Ambulance transport provided by a non-Network provider will be determined as described in Section 3, How the Plan Works.	*Ground and/or Air Ambulance* 90% after you meet the Network Annual Deductible 90% after you meet the Network Annual Deductible	
Bones or Joints of the Jaw and Facial Region	90% after you meet the Annual Deductible	70% after you meet the Network Annual Deductible
Cellular and Gene Therapy Services must be received at a Designated Provider.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Non-Network Benefits are not available
Cleft Lip/Cleft Palate Treatment	90% after you meet the Annual Deductible	70% after you meet the Network Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated Network and Network	**Non-Network**
Clinical Trials Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this section. Benefits are available when the Covered Health Services are provided by either Network or non-Network providers.	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section.	
Congenital Heart Disease (CHD) Surgeries	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Dental Services - Accident Only	90% after you meet the Annual Deductible	90% after you meet the Network Annual Deductible
Dental Services – Anesthesia and Hospitalization See Section 6, *Additional Coverage Details*, for limits.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section. Subject to a Copay reduction or waiver as stated in *Physician's Office Services – Sickness and Injury* in this section below.	
Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* in this section and in Section 15, *Prescription Drugs*.	
Durable Medical Equipment (DME)	90% after you meet the Annual	70% after you meet the Annual

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated Network and Network	**Non-Network**
	Deductible	Deductible
Emergency Health Services – Outpatient If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Hospital will apply instead. This does not apply to services provided to stabilize an Emergency after admission to a Hospital. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described under *Eligible Expenses* in Section 3: *How the Plan Works*.	$300 Copay then 100% of eligible expenses after you meet the Network Annual Deductible.	
Enteral Formulas	90% after you meet the Annual Deductible	70% after you meet the Network Annual Deductible
Gender Dysphoria	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in the *Schedule of Benefits*.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in the *Schedule of Benefits*.
Hearing Aids Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every three calendar years.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Home Health Care	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Hospice Care	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated Network and Network	**Non-Network**
Hospital - Inpatient Stay	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Infertility Services See Section 6, *Additional Coverage Details*, for limits	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Jawbone and Joints of Facial Region	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics - Outpatient ■ PSA Screening ■ Lab Testing Outpatient (Diabetes Health Plan).	90% after you meet the Annual Deductible **Mammograms** 100% 100% 100% for HbA1c, LDL Cholesterol and preventive cancer screenings with a Diabetes-related Diagnosis; Otherwise, 100% after you meet the Annual Deductible	70% after you meet the Annual Deductible **Mammograms** 100% 90% after you meet the Annual Deductible 70% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	90% after you meet the Annual Deductible **Mammograms** 100%	70% after you meet the Annual Deductible **Mammograms** 100%
Mental Health Services ■ Hospital - Inpatient Stay ■ Physician's Office Services (Copay is per visit)	90% after you meet the Annual Deductible 100% after you pay a	70% after you meet the Annual Deductible 70% after you meet the Annual

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated Network and Network	**Non-Network**
■ Virtual Behavioral Health Therapy and Coaching	$30 Copay **Designated Network (**AbleTo Therapy 360**)** 100% 100% after you pay a $30 Copay per session for Partial Hospitalization/ Intensive Outpatient Treatment	Deductible Not Covered 70% for Partial Hospitalization/ Intensive Outpatient Treatment after you meet the Annual Deductible
Neurobiological Disorders - Autism Spectrum Disorder Services ■ Hospital - Inpatient Stay ■ Physician's Office Services (Copay is per visit)	90% after you meet the Annual Deductible 100% after you pay a $30 Copay 100% after you pay a $30 Copay per session for Partial Hospitalization/ Intensive Outpatient Treatment	70% after you meet the Annual Deductible 70% after you meet the Annual Deductible 70% for Partial Hospitalization/ Intensive Outpatient Treatment after you meet the Annual Deductible
Obesity Surgery ■ Physician's Office Services (Copay is per visit)	100% after you pay a $30 Copay /$50 Copay for Specialist	Not Covered

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated Network and Network	**Non-Network**
■ Tier 1 Physician's Office Services (Copay is per visit)	100% after you pay a $30 Copay for Tier 1 Providers	Not Covered
■ Physician Fees for Surgical and Medical Services	100% after you meet the Annual Deductible	Not Covered
■ Hospital - Inpatient Stay	90% after you meet the Annual Deductible	Not Covered
■ Lab and x-ray	90% after you meet the Annual Deductible	Not Covered
Osteoporosis Treatment	100% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Ostomy Supplies Up to $10,000 per calendar year	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient	100%	70% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services		
■ Surgery in office	100% after you meet the PCP/Specialist Copay	70% after you meet the Annual Deductible
■ All Other Services	100% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Covered Health Services provided by a non-Network Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable deductible) as if those services were provided by a Network provider; however Eligible Expenses will be determined as described in Section 3, How		

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated Network and Network	**Non-Network**
the Plan Works, under Eligible Expenses.		
Physician's Office Services - Sickness and Injury (No copayment applies when no Physician charge is assessed)		
	Designated Network	
■ Primary Physician (Copay is per visit)	100% after you pay a $30 Copay	70% after you meet the Annual Deductible
- Diabetes-related diagnosis.	100%	70% after you meet the Annual Deductible
■ Specialist Physician (Copay is per visit)	100% after you pay a $30 Copay	70% after you meet the Annual Deductible
- Diabetes-related diagnosis.	100%	70% after you meet the Annual Deductible
	Network	
■ Primary Physician (Copay is per visit)	100% after you pay a $30 Copay	70% after you meet the Annual Deductible
- Diabetes-related diagnosis.	100%	70% after you meet the Annual Deductible
■ Specialist Physician (Copay is per visit)	100% after you pay a $50 Copay	70% after you meet the Annual Deductible
- Diabetes-related diagnosis.	100%	70% after you meet the Annual Deductible
■ Home Visit	90% after you meet	70% after you meet

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated Network and Network	**Non-Network**
	the Annual Deductible	the Annual Deductible
	Designated Network	
■ OB/GYN office Visit (Copay is per visit)	$30 Copay per visit then 100%	70% after you meet the Annual Deductible
	Network	
	$50 Copay per visit then 100%	70% after you meet the Annual Deductible
■ Allergy Injections (Copay is per visit)	$5 per visit then 100%.	70% after you meet the Annual Deductible
Pregnancy – Maternity Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Preventive Care Services		
■ Physician Office Services	100%	70% after you meet the Annual Deductible
- Diabetes-related diagnosis.	100%	70% after you meet the Annual Deductible
■ Lab, X-ray or Other Preventive Tests	100%	70% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated Network and Network	**Non-Network**
■ Breast Pumps	100%	70% after you meet the Annual Deductible
Prosthetic Devices Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every three calendar years.	90% of eligible expenses after you meet the Annual Deductible	70% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment (Copay is per visit)	***For Manipulative Treatment*** 100% after you pay a $50 Copay ***For all other covered outpatient therapy*** 90% after you meet the Annual Deductible	70% after you meet the Annual Deductible 70% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	90% after you met the Annual Deductible **Preventive and Diagnostic Colonoscopies** 100%	70% after you meet the Annual Deductible 70% after you meet the Annual Deductible70% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	90% after you meet the Annual	70% after you meet the Annual

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated Network and Network	**Non-Network**
Up to 60 days per calendar year	Deductible	Deductible
Substance-Related and Addictive Disorders Services		
■ Hospital - Inpatient Stay	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
■ Physician's Office Services (Copay is per visit)	100% after you pay a $30 Copay	70% after you meet the Annual Deductible
	100% after you pay a $30 Copay per session for Partial Hospitalization/ Intensive Outpatient Treatment	70% for Partial Hospitalization/ Intensive Outpatient Treatment after you meet the Annual Deductible
Surgery - Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Therapeutic Treatments - Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Transplantation Services For Network Benefits, transplantation services must be received by a Designated Provider. The Claims Administrator does not require that cornea transplants be performed by a Designated Provider in order for you to receive Network Benefits.	Depending upon where the Covered Health Services is provided, Benefits for transplantation services will be the same as those stated under each Covered Health Services category in this section.	
Travel and Lodging (If services rendered by a Designated Provider)	For patient and companion(s) of patient undergoing cancer, Congenital Heart Disease treatment, obesity surgery, or transplant procedures	

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:	
	Designated Network and Network	**Non-Network**
Urgent Care Center Services (Copay is per visit)	100% after you pay a $50 Copay	70% after you meet the Annual Deductible
Urinary Catheters	90% after you meet the Annual Deductible	90% after you meet the Annual Deductible
Virtual Care Services	100% after you pay a $15 Copay	Not Covered
Vision Examinations Up to one exam per calendar year.	100%	70% after you meet the Annual Deductible
- Diabetes-related diagnosis. See Section 6, *Additional Coverage Details*, for limits.	100% for retinal exam with a diabetes diagnosis	70% after you meet the Annual Deductible
Wigs Up to $300 per calendar year	100% after you pay a $40 Copay	100% after you pay a $40 Copay

[1]You must obtain prior authorization from the Claims Administrator, as described in Section 4, *Personal Health Support and Prior Authorization* to receive full Benefits before receiving certain Covered Health Services from a non-Network provider. In general, if you visit a Network provider, that provider is responsible for obtaining prior authorization from the Claims Administrator before you receive certain Covered Health Services. See Section 6, *Additional Coverage Details* for further information.

[2]These Benefits are for Covered Health Services provided through CRS by a Designated Provider. For oncology services not provided through CRS, the Plan pays Benefits as described under *Physician's Office Services, Physician Fees for Surgical and Medical Services*, *Hospital - Inpatient Stay*, *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic* Lab, *X-Ray and Diagnostics – Outpatient*, and *Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient*.

Enhanced Benefits

In addition to the Benefits listed above, City of Tampa, through UnitedHealthcare, also offers a way for individuals and their eligible and enrolled Dependents who have been

diagnosed with a Diabetes-related Condition to receive a reduction or waiver of Copays or Annual Deductibles with respect to certain benefits. In order to receive these enhanced benefits, you must meet all of the requirements identified. Your participation is completely voluntary; however, if you do not meet all of the criteria identified below, your benefits will paid at the levels described in the above table of this section and in Section 15, *Outpatient Prescription Drugs* and you will not be eligible for these enhanced benefits in the following Plan year.

Your compliance with regard to the participation criteria (outlined in the table below) will be monitored on an ongoing basis to ensure compliance and eligibility. At the end of each calendar year, if you have not met the criteria for that year, you will not be eligible for the enhanced diabetes benefits the following calendar year (if offered).

The table below provides an overview of the enhanced benefits available under the Plan. Any benefits not specifically identified below will be paid as identified earlier in this section and in Section 15, *Outpatient Prescription Drugs*.

Condition	Criteria	Enhanced Benefit
Diabetes-related Condition	You must: ■ Be at least 18 years old. ■ Visit your Physician between two and four times each calendar year. ■ Receive the following tests and exams: - Hemoglobin A1C check (members with diabetes only) between two and four times each calendar year. - LDL cholesterol check once every calendar year. - Creatinine or Microalbuminuria (members with diabetes only) check once every calendar year. - Retinal eye exam (members with diabetes only) once every calendar year. - Colon screening (age 50 or older) as follows: Colonoscopy once every ten years, OR Sigmoidoscopy once every five years, OR Fecal occult blood test once every year. - Mammogram (females age 40 or older) once every two calendar years. - PSA test (males age 40 or older) discussed annually with your Physician but as recommended by your Physician. ■ Enroll and participate in at least one online wellness program available through **www.myuhc.com**. ■ Enroll and participate in the Disease Management Program[1] most appropriate for you (when asked to participate by the Claims Administrator).	In order to receive: ■ Reduced/waived Copay for in-network *Physician's Office Service – Sickness and Injury* and Specialist Physician's Office Services with a Diabetes-related Condition and certain tier-1 and tier-2[2,3] Prescription Drug Products in the following categories: - Certain diabetes medications and supplies (including insulins and oral glycemics). - ACE Inhibitors/ARBs to treat high blood pressure. - Statins to treat high cholesterol. - antidepressants.

[1]Additional information regarding these programs can be found in Section 7, *Clinical Programs and Resources*.

[2]Medications in these categories that are in tier-3 will not be paid at the reduced or waived Copay. Instead, those medications will be paid according to the table in Section 15, *Outpatient Prescription Drugs*.

[3]You may access information on the list of Prescription Drug Products that are subject to the reduced or waived Copay through the Internet at **www.myuhc.com** or by calling the number on your ID card.

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to obtain prior authorization before you receive them, and any reduction in Benefits that may apply if you do not call to obtain prior authorization.

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with Benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must obtain prior authorization from the Claims Administrator as required. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions*.

Benefits are provided for services delivered via Telehealth/Telemedicine. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the table.

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, *Glossary* for the definition of Emergency.

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

The Plan also covers transportation provided by a licensed professional ambulance (either ground or Air Ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- from a non-Network Hospital to a Network Hospital;
- to a Hospital that provides a higher level of care that was not available at the original Hospital;
- to a more cost-effective acute care facility; or
- from an acute facility to a sub-acute setting.

Prior Authorization Requirement

In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. For Non-Network Benefits, if you are requesting non-Emergency Air Ambulance services, (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency Air Ambulance transport), you must obtain prior authorization as soon as possible before transport.

If you fail to obtain prior authorization from the Claims administrator, Benefits will be reduced to 50% of Eligible Expenses.

Bones or Joints of the Jaw and Facial Region

Benefits are provided for diagnostic and surgical procedures involving bones or joints of the jaw and facial region to treat conditions caused by congenital or developmental deformity, Sickness or Injury.

Please note that Benefits are not available for care or treatment of the teeth or gums, intraoral prosthetic devices or surgical procedures for cosmetic purposes. This Benefit includes evaluation and treatment of temporomandibular joint syndrome (TMJ) when related to congenital, developmental deformity, injury or disease.

Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office.

Benefits for CAR-T therapy for malignancies are provided as described under *Transplantation Services*.

Cleft Lip/Cleft Palate Treatment

Benefits are provided for treatment of cleft lip and cleft palate for any Dependent under the age of 18. Benefits include medical, dental, speech therapy, audiology and nutritional Covered Health Services ordered by a Physician.

Clinical Trials

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

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

- other diseases or disorders which are not life threatening for which, as UnitedHealthcare determines, a clinical trial meets the qualifying clinical trial criteria stated below.

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

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

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial;
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- the Experimental or Investigational Service or item. The only exceptions to this are:
  - certain Category B devices;
  - certain promising interventions for patients with terminal illnesses; and
  - other items and services that meet specified criteria in accordance with our medical and drug policies;
- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI));
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Healthcare Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);

- a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA);
- a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
- The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
  - ♦ comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
  - ♦ ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

■ the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;

■ the study or investigation is a drug trial that is exempt from having such an investigational new drug application;

■ the clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial; or

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

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization as soon as the possibility of participation in a Clinical Trial arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD services:

■ outpatient diagnostic testing;

■ evaluation;

■ surgical interventions;

■ interventional cardiac catheterizations (insertion of a tubular device in the heart);

■ fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology); and

■ approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks or Personal Health Support to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the toll-free number on your ID card for information about CHD services.

If you receive Congenital Heart Disease services from a provider that is not a Designated Provider, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a CHD surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program.

Dental Services - Accident Only

Dental services are covered by the Plan when all of the following are true:

- treatment is necessary because of accidental damage;
- dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth;
- dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and
- the dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

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

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

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

The Plan pays for treatment of accidental Injury only for:

- emergency examination;
- necessary diagnostic x-rays;
- endodontic (root canal) treatment;
- temporary splinting of teeth;
- prefabricated post and core;
- simple minimal restorative procedures (fillings);
- extractions;
- post-traumatic crowns if such are the only clinically acceptable treatment; and
- replacement of lost teeth due to the Injury by implant, dentures or bridges.

The Plan also provides Benefits for certain oral surgical operations as follows:

- excision of partially or completely impacted teeth;
- excisions of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examinations;
- surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- reduction of fractures and dislocation of the jaw;
- external incision and drainage of cellulitis;
- incision of accessory sinuses, salivary glands or ducts;
- frenectomy (the cutting of the tissue in the midline of the tongue); and
- orthognathic surgery for a congenital anomaly, bodily injury or sickness causing a functional impairment.

Dental Services – Anesthesia and Hospitalization

Benefits include Covered Health Services provided in a Hospital or Alternate Facility for dental conditions likely to result in a medical condition if left untreated.

Benefits are limited to treatment of a Covered Person who:

- is under 8 years of age; and
- is determined by a Physician to require dental treatment in a Hospital or Alternate Facility, due to a complex dental condition or a developmental disability that prevents effective treatment in a dental office; or
- has one or more medical conditions that would create undue medical risk if dental treatment were provided in a dental office.

Benefits do not include expenses for the diagnosis and treatment of dental disease.

Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under Durable Medical Equipment. Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described is Section 15, *Outpatient Prescription Drugs*.

Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment* in this section.

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Durable Medical Equipment (DME)

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

- ordered or provided by a Physician for outpatient use;

- used for medical purposes;
- not consumable or disposable;
- not of use to a person in the absence of a Sickness, Injury or disability;
- durable enough to withstand repeated use; and
- appropriate for use in the home.

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

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- negative pressure wound therapy pumps (wound vacuums);
- burn garments;
- insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section;
- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage; and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

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

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

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

Benefits for dedicated speech generating devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

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

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

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining any DME or orthotic that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Emergency Health Services - Outpatient

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

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims Administrator is notified within one business day of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

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

Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify the Claims Administrator within one business day or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

Enteral Formulas

Benefits include prescription and nonprescription enteral formulas, including food products modified to be low protein for inherited diseases of amino acids and organic acids, when the following are true:

- prescribed or recommended by a Physician;
- necessary for the treatment of inherited diseases of amino acid, organic acid, carbohydrate or fat metabolism, including malabsorption originating from Congenital Anomalies; and
- the Covered Person is 30 years of age or younger.

Gender Dysphoria

Benefits for the treatment of Gender Dysphoria limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses are provided as described under *Mental Health Services* in your SPD.
- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is provided as described under *Pharmaceutical Products – Outpatient* in your SPD.
  - Cross-sex hormone therapy dispensed from a pharmacy is provided as described under Section 15, *Outpatient Prescription Drugs*.
- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:
  - Bilateral mastectomy or breast reduction
  - Clitoroplasty (creation of clitoris)
  - Hysterectomy (removal of uterus)
  - Labiaplasty (creation of labia)
  - Metoidioplasty (creation of penis, using clitoris)

- Orchiectomy (removal of testicles)
- Penectomy (removal of penis)
- Penile prosthesis
- Phalloplasty (creation of penis)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prosthesis
- Urethroplasty (reconstruction of urethra)
- Vaginectomy (removal of vagina)
- Vaginoplasty (creation of vagina)
- Vulvectomy (removal of vulva)

■ Benefit includes all related medical visits

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Covered Person must provide documentation of the following for breast surgery:

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

The Covered Person must provide documentation of the following for genital surgery:

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

- Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

Prior Authorization Requirement for Surgical Treatment
For Non-Network Benefits you must obtain prior authorization as soon as the possibility of surgery arises.

If you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

It is important that you notify the Claims Administrator as soon as the possibility of surgery arises. Your notification allows the opportunity for the Claims Administrator to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.

Prior Authorization Requirement for Non-Surgical Treatment
Depending upon where the Covered Health Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Service category.

Hearing Aids

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

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

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

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

Any combination of Network Benefits and Non-Network Benefits for hearing aids are limited to a single purchase (including repair/replacement) per hearing impaired ear every three calendar years.

Home Health Care

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

- ordered by a Physician;
- provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- not considered Custodial Care, as defined in Section 14, *Glossary*; and
- provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.

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

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator five business days before receiving services, including nutritional foods, as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Hospice Care

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

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator within 24 hours of admission for an Inpatient Stay in a hospice facility.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- non-Physician services and supplies received during an Inpatient Stay;

- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

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

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

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

Prior Authorization Requirement
Please remember for Non-Network Benefits, for:

- A scheduled admission, you must obtain prior authorization five business days before admission.
- A non-scheduled admission (including Emergency admissions), you must provide notification within 24 hours or as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Infertility Services

Services for the treatment of infertility when provided by or under the care or supervision of a Physician, limited to the following procedures:

- Ovulation induction (or controlled ovarian stimulation).
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Pharmaceutical Products for the treatment of infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home.

To be eligible for Benefits, you must meet all of the following:

- You are not able to become pregnant after the following periods of time of regular unprotected intercourse or therapeutic donor insemination:
  - One year, if you are a female under age 35.
  - Six months, if you are a female age 35 or older.

- You are a female under age 44.
- You have infertility not related to voluntary sterilization or to failed reversal of voluntary sterilization.

For the purposes of this Benefit, "therapeutic donor insemination" means using a donor sperm sample to enable a female to become pregnant.

Any combination of Network Benefits and Non-Network Benefits are limited to $5,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Plan. This limit does not include Physician office visits for the treatment of Infertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below.

There are separate limits under the Plan for medical services and *Outpatient Prescription Drugs*.

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

- Surgeon.
- Assistant surgeon.
- Anesthesia.
- Lab tests.
- Specific injections.

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- lab and radiology/x-ray; and
- mammography.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services.)
- Presumptive Drug Tests and Definitive Drug Tests.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Presumptive Drug Tests per calendar year.

Any combination of Network Benefits and Non-Network Benefits is limited to 18 Definitive Drug Tests per calendar year.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

Prior Authorization Requirement
For Non-Network Benefits for Genetic Testing and sleep studies, you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

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

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- diagnostic evaluations, assessment and treatment planning;

- treatment and/or procedures;
- medication management and other associated treatments;
- individual, family and group therapy;
- provider-based case management services;
- crisis intervention;

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement

For Non-Network Benefits for:

- A scheduled admission for Mental Health Services (including an admission for services at a Residential Treatment facility) you must obtain prior authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits, with or without medication management.

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Virtual Behavioral Health Therapy and Coaching

Specialized virtual behavioral health care provided by AbleTo, Inc. ("AbleTo") for Covered Persons with certain co-occurring behavioral and medical conditions.

AbleTo Therapy 360 provides behavioral Covered Health Care Services through virtual therapy and coaching services that are individualized and tailored to your specific health needs. Virtual therapy is provided by licensed therapists. Coaching services are provided by coaches who are supervised by licensed professionals.

There are no deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

- focused on the treatment of core deficits of Autism Spectrum Disorder.
- provided by a Board Certified Applied Behavior Analyst (BCBA) or other qualified provider under the appropriate supervision; and
- focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

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

These Benefits are in addition to the Benefits described in this section under *Autism Spectrum Disorder*.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- diagnostic evaluations, assessment and treatment planning;
- treatment and/or procedures;
- medication management and other associated treatments;
- individual, family and group therapy;
- provider-based case management services;
- crisis intervention;

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
For Non-Network Benefits for:

- A scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including an admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits, with or without medication management; Intensive Behavioral Therapy, including Applied Behavior Analysis (ABA).

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Additional Autism Spectrum Disorder Benefits

Benefits are provided for Covered Health Services for Dependents under 18 years of age or Dependents 18 years of age or older who are in high school and were diagnosed at 8 years of age or younger with Autism Spectrum Disorder. For the purposes of this benefit, "Autism Spectrum Disorder" includes any of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

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

Benefits are provided for the generally recognized services listed below when prescribed by the treating Physician. For the purpose of this benefit, "Applied Behavioral Analysis" is defined as the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

- Well-baby and well-child screening for diagnosing the presence of Autism Spectrum Disorder.
- "Applied Behavioral Analysis" when provided by an individual certified pursuant to s. 393.17 or an individual licensed under chapter 490 or chapter 491.
- Speech therapy.
- Occupational therapy.
- Physician physical therapy.

These Benefits are in addition to those described in this section under *Neurobiological Disorders - Autism Spectrum Disorder Services* and *Rehabilitation Services - Outpatient Therapy*.

Depending upon where the Covered Health Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Service category in this section.

Obesity Surgery

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

- you have a minimum Body Mass Index (BMI) of 40; or
- you have a minimum BMI of 35 with at least 1 complicating co-morbid condition present (such as sleep apnea or diabetes) directly related to, or exacerbated by obesity.

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

- the surgery is performed at a Network Hospital by a Network surgeon even if there are no Network Hospitals near you.

Surgical treatment of obesity when provided by or under the direction of a Physician when all of the following are true:

- you have enrolled in the Bariatric Resource Services (BRS) program.
- you have a minimum Body Mass Index (BMI) of 40, or greater than 35 with at least one complicating coexisting medical condition or disease present.
- you are over the age of 18 or, for adolescents, have achieved greater than 95% of estimated adult height AND a minimum Tanner Stage of 4.
- you have a 3-month physician or other health care provider supervised diet documented within the last 2 years.
- you have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation.
- you are having your first bariatric surgery under your plan, unless there were complications with your first procedure.

See *Bariatric Resource Services (BRS)* in Section 7*, Clinical Programs and Resources* for more information on the BRS program.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 14, *Glossary* and are not Experimental or Investigational or Unproven Services.

Benefits are limited to one surgery per lifetime, unless there are complications.

Excess skin removal is **NOT** covered, unless medically necessary.

Osteoporosis Treatment

Benefits are provided for the diagnosis, treatment and appropriate management of osteoporosis. Covered Health Services include Food and Drug Administration's approved technologies, including but not limited to bone mass measurements, when ordered by your Physician.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

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

Any combination of Network Benefits and Non-Network Benefits is limited to $10,000 per calendar year.

Pharmaceutical Products - Outpatient

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

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits for medication normally available by prescription or order or refill are provided as described under your Outpatient Prescription Drug Plan. Benefits under this section do not include medications for the treatment of infertility.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, UnitedHealthcare may direct you to a designated dispensing entity with whom UnitedHealthcare has an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a designated dispensing entity and you/your provider choose not to obtain your Pharmaceutical Product from a designated dispensing entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting UnitedHealthcare at www.myuhc.com or by calling the telephone number on your ID card.

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Physician Fees for Surgical and Medical Services

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

Physician's Office Services - Sickness and Injury

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

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

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

Benefits for preventive services are described under *Preventive Care Services* in this section.

Benefits under this section include lab, radiology/x-ray or other diagnostic services performed in the Physician's office.

Please Note
Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

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

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

These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The Hospital or other provider is not

required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

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

Prior Authorization Requirement
For Non-Network Benefits you must obtain prior authorization from the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Clinical Programs and Resources*, for details.

Preventive Care Services

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

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive care Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on how to access Benefits for breast pumps by going to **www.myuhc.com** or by calling the number on your ID card. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with

childbirth. These Benefits are described under Section 5, *Plan Highlights*, under *Covered Health Services*.

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

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. The Claims Administrator will determine the following:

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

For questions about your preventive care Benefits under this Plan call the number on your ID card.

Prosthetic Devices

Benefits are paid by the Plan for external prosthetic devices that replace a limb or body part limited to:

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

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

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

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

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

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

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining prosthetic devices that exceed $1,000 in cost per device. If prior authorization is not obtained as required, Benefits will be reduced to 50% of Eligible Expenses.

Reconstructive Procedures

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

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

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

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Prior Authorization Requirement
For Non-Network Benefits for:

- A scheduled reconstructive procedure, you must obtain prior authorization from the Claims Administrator five business days before a scheduled reconstructive procedure is performed.
- A non-scheduled reconstructive procedure, you must provide notification within 24 hours or as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services (including habilitative services) limited to:

- physical therapy;
- occupational therapy;
- Manipulative Treatment;
- speech therapy;
- post-cochlear implant aural therapy;
- cognitive rehabilitation therapy following a post-traumatic brain Injury or stroke;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

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

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Covered Health Services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is provided to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is ordered by a Physician and provided and administered by a licensed provider.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

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

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

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

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

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, s. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or stroke.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

Benefits under this section include:

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

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

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

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

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

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

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

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

Benefits are available only if:

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

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

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

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 14, *Glossary*.

Any combination of Network Benefits and Non-Network Benefits is limited to 60 days per calendar year.

Prior Authorization Requirement
Please remember for Non-Network Benefits for:

- A scheduled admission, you must obtain prior authorization five business days before admission.
- A non-scheduled admission (or admissions resulting from an Emergency) you must provide notification within 24 hours or as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office.

Benefits include the following services:

- diagnostic evaluations, assessment and treatment planning;
- treatment and/or procedures;
- medication management and other associated treatments;
- individual, family and group therapy.
- provider-based case management services;
- crisis intervention;
-

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care.

Prior Authorization Requirement
For Non-Network Benefits for:

- A scheduled admission for Substance-Related and Addictive Disorders Services (including an admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator five business days before admission.
- A non-scheduled admission (including Emergency admissions) you must provide notification as soon as is reasonably possible.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits, with or without medication management.

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

Surgery - Outpatient

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

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

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

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

Prior Authorization Requirement
For Non-Network Benefits for sleep apnea surgeries you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or, for non-scheduled services, within 24 hours or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

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

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

Benefits under this section include:

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

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services*.

Prior Authorization Requirement
For Non-Network Benefits for the following outpatient therapeutics you must obtain prior authorization from the Claims Administrator five business days before scheduled services are received or, for non-scheduled services, as soon as is reasonably possible. Services that require prior authorization: dialysis, IV infusion, radiation oncology, intensity modulated radiation therapy and MR-guided focused ultrasound.

If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.

Transplantation Services

Organ and tissue transplants including CAR-T cell therapy for malignancies when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow including CAR-T cell therapy for malignancies, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures may be received at a Designated Provider or Network facility that is not a Designated Provider or a non-Network facility.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from the Claims Administrator for a cornea transplant nor is the cornea transplant required to be performed by a Designated Provider.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with transplant services received by a Designated Provider.

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator, as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section.

Urinary Catheters

Benefits for indwelling and intermittent urinary catheters for incontinence or retention.

Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

Virtual Care Services

Virtual care for Covered Health Services that includes the diagnosis and treatment of less serious medical conditions. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health specialist, outside of a medical facility (for example, from home or from work).

Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.

Benefits are available for the following:

- Urgent on-demand health care delivered through live audio with video-conferencing or audio only technology for treatment of acute but non-emergency medical needs.

Please Note: Not all medical conditions can be treated through virtual care. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed.

Benefits do not include email, fax and standard telephone calls, or for services that occur within medical facilities (*CMS* defined originating facilities).

Vision Examinations

The Plan pays Benefits for one routine vision exam, including refraction, to detect vision impairment by a provider in the provider's office or outpatient facility every calendar year.

Benefits for eye examinations required for the diagnosis and treatment of a Sickness or Injury are provided under *Physician's Office Services - Sickness and Injury*.

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis regardless of the reason of hair loss.

Any combination of Network Benefits and Non-Network Benefits is limited to $300 per calendar year.

SECTION 7 - CLINICAL PROGRAMS AND RESOURCES

What this section includes:
Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools;
- Disease Management Services; and
- Women's Health/Reproductive.

City of Tampa believes in giving you the tools you need to be an educated health care consumer. To that end, City of Tampa has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and City of Tampa are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Consumer Solutions and Self-Service Tools

Health Actions Portal - Diabetes Health Plan

This Plan includes access to an online portal available specifically for members enrolled in the Diabetes Health Plan for monitoring your progress toward meeting all the participation criteria described in Section 5, *Plan Highlights* and Section 15, *Outpatient Prescription Drugs* of this SPD required to maintain eligibility in the Plan. You're encouraged to visit the site frequently to keep abreast of the activities you should be completing be eligible for enhanced benefits and ensure that your information is up-to-date. The site also includes links to other helpful tools and resources for diabetes self-care and prevention. You can visit the site by going to dhp.healthmine.com.

Employee Assistance Program (EAP)

UnitedHealthcare offers free counseling and referral services nationwide through the Employee Assistance Program (EAP). Using a solution focused approach to care, they tailor their interventions to meet your individual needs. The program can help you and your immediate family members cope with issues such as:

- family or relationship problems;
- parenting difficulties;

- work-related problems;
- financial and legal issues;
- substance use or abuse;
- grief and loss; and
- anxiety.

Call the toll-free phone number on your ID card to speak to a specially trained, master's-level specialist who will recommend the right resources for your specific life concern. Services are available any time, 24 hours a day, seven days per week and are strictly confidential in accordance with state and federal laws.

Health Survey

You are invited to learn more about your health and wellness at **www.myuhc.com** and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way.

To find the health survey, log in to **www.myuhc.com**. After logging in, access your personalized *Health & Wellness* page. If you need any assistance with the online survey, please call the number on your ID card.

NurseLine℠

NurseLine℠ is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that City of Tampa has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take Prescription Drugs safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLine℠ gives you another convenient way to access health information. By calling the same toll-free number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine[SM] is available to you at no cost. To use this convenient service, simply call the toll-free number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLine[SM].

Your child is running a fever and it's 1:00 AM. What do you do?
Call NurseLine[SM] toll-free, any time, 24 hours a day, seven days a week. You can count on NurseLine[SM] to help answer your health questions.

With NurseLine[SM], you also have access to nurses online. To use this service, log onto **www.myuhc.com** and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Note: If you have a medical emergency, call 911 instead of logging onto **www.myuhc.com**.

Onsite Nurse Liaison

How can a Nurse Liaison help me?

As the City of Tampa Nurse Liaison, the on-site nurse is available on-site to meet with you to discuss any issues or concerns you may have regarding your healthcare.

As a Nurse Liaison she can:

- Provide education and support on prevention and/or management of health conditions such as Diabetes and heart disease
- Assist with referrals to UHC clinical and community programs to support your health goals, promote condition self-management skills, and assist with cost savings
- Help you find a physician to receive annual wellness exams, preventive care services, appropriate test and screenings for health conditions, and manage your care
- Review your medications for compliance, drug interactions, and understanding of use
- Teach you how to navigate UHC wellness tools and resources (myuhc.com)
- Empower you to make behavior changes to achieve a healthier lifestyle and promote better health

This resource is available free of charge as a City of Tampa Employee.

Will my personal information that I share with my Nurse Liaison be protected?

Yes. All information shared with the nurse liaison is strictly confidential and will not be shared with your employer. All of your personal health information will be protected in accordance with HIPAA.

Reminder Programs

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

- Mammograms for women.
- Pediatric and adolescent immunizations.
- Cervical cancer screenings for women.
- Comprehensive screenings for individuals with diabetes.
- Influenza/pneumonia immunizations for enrollees.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- Access to health care information.
- Support by a nurse to help you make more informed decisions in your treatment and care.
- Expectations of treatment.
- Information on providers and programs.

Conditions for which this program is available include:

- Back pain.
- Knee & hip replacement.
- Prostate disease.
- Prostate cancer.
- Benign uterine conditions.
- Breast cancer.
- Coronary disease.
- Bariatric surgery.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your ID card.

UnitedHealth Premium℠ Program

UnitedHealthcare designates Network Physicians and facilities as UnitedHealth Premium℠ Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth Premium℠ Program was designed to:

- help you make informed decisions on where to receive care;
- provide you with decision support resources; and
- give you access to Physicians and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria.

For details on the UnitedHealth Premium℠ Program including how to locate a UnitedHealth Premium℠ Physician or facility, log onto **www.myuhc.com** or call the toll-free number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for Network providers available in your Plan through the online provider directory;
- access all of the content and wellness topics from NurseLine including Live Nurse Chat 24 hours a day, seven days a week;
- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your UnitedHealthcare ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Copays and Annual Deductibles;

- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or, print a temporary ID card.

Want to learn more about a condition or treatment?
Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Health Management Virtual Behavioral Health Therapy and Coaching Programs

The Virtual Behavioral Health Therapy and Coaching program identifies Covered Persons with chronic medical conditions that frequently co-occur with mental health challenges, and provides support through virtual sessions for depression, anxiety and stress that often accompany chronic medical health issues like diabetes, cancer or cardiac conditions. This means that you may be called by a licensed clinical social worker or coach. You may also call the program and speak with a licensed clinical social worker or coach.

This Plan includes access to an online portal available specifically for Covered Persons enrolled in the program for monitoring your progress toward meeting all the participation criteria.

You're encouraged to visit the site frequently to keep abreast of the activities you should be completing and ensure that your information is up-to-date. The site also includes links to other helpful tools and resources for Behavioral Health.

The program is provided through AbleTo, Inc. Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your ID card.

Disease Management Services

Disease Management Services

If you have been diagnosed with or are at risk for developing certain chronic medical conditions you may be eligible to participate in a disease management program at no cost to you. The heart failure, coronary artery disease, diabetes and asthma programs are designed to support you. This means that you will receive free educational information, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- educational materials that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;
- access to educational and self-management resources on a consumer website;

- an opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care; and
- toll-free access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
  - education about the specific disease and condition,
  - medication management and compliance,
  - reinforcement of on-line behavior modification program goals,
  - preparation and support for upcoming Physician visits,
  - review of psychosocial services and community resources,
  - caregiver status and in-home safety,
  - use of mail-order pharmacy and Network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your ID card.

Complex Medical Conditions Programs and Services

Bariatric Resource Services (BRS)

Your Plan offers Bariatric Resource Services (BRS) program. The BRS program provides you with:

- Specialized clinical consulting services to Participants and Enrolled Dependents to educate on obesity treatment options.
- Access to specialized Network facilities and Physicians for obesity surgery services.

You must access the Bariatric Resource Services program by calling the number on your ID card.

See Obesity Surgery in Section 6, Additional Coverage Details for obesity surgery requirements.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the Travel and Lodging Assistance Program.

Cancer Resource Services (CRS) Program

Your Plan offers Cancer Resource Services (CRS) program to provide you with access to information and member assistance through a team of specialized cancer nurse consultants and access to one of the nation's leading cancer programs.

To learn more about *CRS*, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card or call the program directly at 1-866-936-6002.

Coverage for oncology services and oncology-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the *Travel and Lodging Assistance Program*.

Comprehensive Kidney Solution (CKS) program

For participants diagnosed with Kidney Disease, your Plan offers the Comprehensive Kidney Solution (CKS) program to help you manage the effects of advanced Chronic Kidney Disease (CKD) through End-stage Renal Disease (ESRD).

Should the disease progress to the point of needing dialysis, CKS provides access to top-performing dialysis centers. That means you will receive treatment based on a "best practices" approach from health care professionals with demonstrated expertise.

There are hundreds of contracted dialysis centers across the country, but in situations where you cannot conveniently access a contracted dialysis center, CKS will work to negotiate patient-specific agreements on your behalf.

To learn more about Comprehensive Kidney Solutions, visit **www.myoptumhealthcomplexmedical.com** or call the number on your ID card.

Coverage for dialysis and kidney-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you decide to no longer participate in the program, please contact CKS of your decision.

Kidney Resource Services (KRS) program
End-Stage Renal Disease (ESRD)

The Kidney Resource Services program provides Covered Persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS program, you'll work with a nurse who will provide you with support and information. The nurse can help you manage other conditions, such as diabetes and high blood pressure. He or she can also help you find doctors, specialists and dialysis centers. This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have been referred to the KRS program by your medical provider or from past claim information. As part of your health insurance benefits, it's available at no extra cost to you.

KRS nurse advocates are available, Monday through Friday toll-free at 1-866-561-7518 (TTY: 711).

Coverage for dialysis and kidney-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Congenital Heart Disease (CHD) Resource Services

UnitedHealthcare provides a program that identifies and supports a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This

program will work with you and your Physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers.

To learn more about CHD Resource Services program, visit **www.myoptumhealthcomplexmedical.com** or call UnitedHealthcare at the number on your ID card or you can call the CHD Resource Services Nurse Team at 888-936-7246.

Coverage for CHD surgeries and related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary. If you are considering any CHD surgeries you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be a considered a Covered Health Service under the Plan.

Your Plan Sponsor is providing you with Travel and Lodging assistance. Refer to the Travel and Lodging Assistance Program.

Transplant Resource Services (TRS) Program

Your Plan offers Transplant Resource Services (TRS) program to provide you with access to one of the nation's leading transplant programs. Receiving transplant services through this program means your transplant treatment is based on a "best practices" approach from health care professionals with extensive expertise in transplantation.

To learn more about Transplant Resource Services, visit **www.myoptumhealthcomplexmedical.com** or call the number on your ID card.

Coverage for transplant and transplant-related services are based on your health plan's terms, exclusions, limitations and conditions, including the plan's eligibility requirements and coverage guidelines. Participation in this program is voluntary.

Your Plan Sponsor is providing you with Travel and Lodging assistance. For more information on the *Travel and Lodging Assistance Program*, refer to the provision below.

Travel and Lodging Assistance Program

Your Plan Sponsor may provide you with Travel and Lodging assistance. Travel and Lodging assistance is only available for you or your eligible family member if you meet the qualifications for the benefit, including receiving care at a Designated Provider and the distance from your home address to the facility. Eligible Expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts.

If you have specific questions regarding the Travel and Lodging Assistance Program, please call the Travel and Lodging office at 1-800-842-0843.

Travel and Lodging Expenses

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

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the qualified procedure provided by a Designated Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- The Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the Designated Provider.
- Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Plan participant if the reimbursement exceeds the per diem rate.
- The bariatric, cancer, and congenital heart disease and transplant programs offer a combined overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by you and reimbursed under the Plan in connection with all qualified procedures.

The Claims Administrator must receive valid receipts for such charges before you will be reimbursed. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50.00 per day, for the patient or the caregiver if the patient is in the Hospital.
- A per diem, up to $100.00 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child.

  Examples of items that are not covered:

- Groceries.
- Alcoholic beverages.
- Personal or cleaning supplies.
- Meals.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, or movie rentals.

Transportation

- Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the Designated Provider.
- Taxi fares (not including limos or car services).

- Economy or coach airfare.
- Parking.
- Trains.
- Boat.
- Bus.
- Tolls.

Women's Health/Reproductive

Maternity Support Program

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get valuable educational information, advice and comprehensive case management by calling the number on your ID card. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- Enrollment by an OB nurse.
- Pre-conception health coaching.
- Written and online educational resources covering a wide range of topics.
- First and second trimester risk screenings.
- Identification and management of at- or high-risk conditions that may impact pregnancy.
- Pre-delivery consultation.
- Coordination with and referrals to other benefits and programs available under the medical plan.
- A phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more.
- Post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the number on your ID card.

As a program participant, you can always call your nurse with any questions or concerns you might have.

Neonatal Resource Services (NRS)

NRS is a program administered by the Claims Administrator or its affiliates made available to you by the Plan Sponsor. NRS provides a dedicated team of experienced Neonatologists, Neonatal Intensive Care Unit (NICU) nurse case managers and social workers who can provide support and assistance to you and your family during your infant's admission to the

NICU. The case manager will also provide discharge planning assistance and ongoing support post-discharge based on your infant's needs.

To take part in the NRS program you or a covered Dependent can call the Claims Administrator at the telephone number on your ID card or call NRS directly at 1-866-534-7209.

SECTION 8 - EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Additional Coverage Details.*

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the SPD says "this includes," or "including but not limiting to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments

1. acupressure
2. acupuncture;
3. aromatherapy;
4. hypnotism;
5. massage therapy;
6. rolfing (holistic tissue massage); and
7. art therapy, music therapy, dance therapy, animal-assisted therapy and other forms of alternative treatment as defined by the National Center for Complimentary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, *Additional Coverage Details.*

Dental

1. dental care, except as identified under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*;

   Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

   Endodontics, periodontal surgery and restorative treatment are excluded.

2. diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include:

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

This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*. This exclusion does not apply to jaw bone and joints of the facial region for which Benefits are provided as described under *Bones or Joints of the Jaw and Facial Region* and *Dental Services - Anesthesia and Hospitalization* in *Section* 6, *Additional Coverage Details*.

3. dental implants, bone grafts, and other implant-related procedures;

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details*.

4. dental braces (orthodontics);

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

   This exclusion does not apply to Benefits as described under *Bones or Joints of the Jaw and Facial Region* and *Dental Services - Anesthesia and Hospitalization* in *Section 6: Additional Coverage Details;* and

6. treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly. This exclusion does not apply to dental services for which Benefits are provided as described under *Cleft Lip/Cleft Palate in Section 6 Additional Coverage Details.*

Devices, Appliances and Prosthetics

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

2. orthotic appliances and devices that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*:

   This exclusion does not apply to cranial molding helmets and cranial banding that meet clinical criteria. Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.

3. cranial molding helmets and cranial banding except when used to avoid the need for surgery, and/or to facilitate a successful surgical outcome.

4. the following items are excluded, even if prescribed by a Physician:

   - blood pressure cuff/monitor;
   - enuresis alarm;
   - non-wearable external defibrillator;
   - trusses;
   - ultrasonic nebulizers;

5. the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect;

6. the replacement of lost or stolen prosthetic devices;

7. devices and computers to assist in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*;

8. oral appliances for snoring.

9. powered and non-powered exoskeleton devices.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See Section 15, *Prescription Drugs*, for coverage details and exclusions.

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

2. self- administered or self-infused medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by UnitedHealthcare the Claims Administrator), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion.

3. growth hormone therapy;

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

5. over the counter drugs and treatments.

6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 6, *Additional Coverage Details*.

7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

9. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

60. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

71. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless

otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

82. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services or Unproven Services, unless the Plan has agreed to cover them as defined in Section 14, *Glossary*.

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

Gender Dysphoria

Cosmetic Procedures, including the following:

- Abdominoplasty.
- Blepharoplasty.
- Breast enlargement, including augmentation mammoplasty and breast implants.
- Body contouring, such as lipoplasty.
- Brow lift.
- Calf implants.
- Cheek, chin, and nose implants.
- Injection of fillers or neurotoxins.
- Face lift, forehead lift, or neck tightening.
- Facial bone remodeling for facial feminizations.
- Hair removal.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.

- Skin resurfacing.
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
- Voice modification surgery.
- Voice lessons and voice therapy.

Foot Care

1. routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*. Routine foot care services that are not covered include:

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

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

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

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

3. treatment of flat feet;

4. treatment of subluxation of the foot;

5. shoe inserts;

6. arch supports;

7. shoes (standard or custom), lifts and wedges; and

8. shoe orthotics.

Medical Supplies and Equipment

1. prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to compression stockings, ace bandages, diabetic strips, and syringes.

This exclusion does not apply to:

- ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.
- disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*;
- the following special supplies, dispensed up to a 30-day supply, when prescribed by your attending health care practitioner:
  - ♦ surgical dressings;
  - ♦ catheters;
  - ♦ colostomy bags, rings and belts; and
- flotation pads; or
- diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*.

2. tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment;

3. the repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect;

4. the replacement of lost or stolen Durable Medical Equipment; and

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

Mental Health, Neurobiological Disorders - Autism Spectrum Disorder and Substance-Related and Addictive Disorders

In addition to all other exclusions listed in this Section 8, *Exclusions*, the exclusions listed directly below apply to services described under *Mental Health Services*, *Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance-Related and Addictive Disorders Services* in Section 6, *Additional Coverage Details*.

1. services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*;

2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and disruptive impulse control and conduct disorders, gambling disorder and paraphilic disorders.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.

6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

7. Transitional Living services.

8. Non -Medical 24-Hour Withdrawal Management.

9. High intensity residential care including American Society of Addiction Medicine (ASAM) criteria for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

Nutrition

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

2. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to nutritional counseling services that are billed as *Preventive Care Services* or to nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:
   - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
   - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional. food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to enteral formula and other modified food products for which Benefits are provided as described under Enteral Nutrition in Section 6, Additional Coverage Details.

3. health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. television;

2. telephone;

3. beauty/barber service;

4. guest service;

5. supplies, equipment and similar incidentals for personal comfort. Examples include:

   - air conditioners;
   - air purifiers and filters;
   - batteries and battery chargers;
   - dehumidifiers and humidifiers;
   - ergonomically correct chairs;
   - non-Hospital beds, comfort beds, motorized beds and mattresses;
   - breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement;
   - car seats;
   - chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
   - electric scooters;
   - exercise equipment and treadmills;
   - hot tubs, Jacuzzis, saunas and whirlpools;
   - medical alert systems;
   - music devices;
   - personal computers;
   - pillows;
   - power-operated vehicles;
   - radios;
   - strollers;
   - safety equipment;
   - vehicle modifications such as van lifts;
   - video players; and
   - home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

Physical Appearance

1. Cosmetic Procedures, as defined in Section 14, *Glossary*, are excluded from coverage. Examples include:

   - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
   - pharmacological regimens;
   - nutritional procedures or treatments;
   - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
   - sclerotherapy treatment of veins.
   - hair removal or replacement by any means;
   - treatments for skin wrinkles or any treatment to improve the appearance of the skin;
   -
   - skin abrasion procedures performed as a treatment for acne;
   - treatments for hair loss;
   - varicose vein treatment of the lower extremities, when it is considered cosmetic; and

- replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;

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

3. weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity; and

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

Procedures and Treatments

1. biofeedback;

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

3. rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment;

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

5. Habilitative services or therapies for the purpose of general well-being or condition in the absence of a disabling condition.

6. speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, a Congenital Anomaly or Autism Spectrum Disorders as identified under *Rehabilitation Services – Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*;

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

8. excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty);

9. psychosurgery (lobotomy);

10. stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings;

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

62. Manipulative Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies;

73. physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter;

85. the following treatments for obesity:

- non-surgical treatment, even if for morbid obesity; and
- surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 6, *Additional Coverage Details*;

96. medical and surgical treatment of hyperhidrosis (excessive sweating);

107. services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered medical or dental in nature: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment and dental restorations. This exclusion does not apply to Benefits described under - *Bones or Joints of the Jaw and Facial Region in Section 6, Additional Coverage Details;*

118. upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors or cancer or obstructive sleep apnea. This exclusion does not apply to Benefits as described under *Bones or Joints of the Jaw and Facial Region* and *Dental Services - Anesthesia and Hospitalization* in *Section 6: Additional Coverage Details*; and

129. breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

20. intracellular micronutrient testing.

21. health care services provided in the emergency department of a Hospital or Alternate Facility that are not for an Emergency.

Providers

Services:

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

2. a provider may perform on himself or herself;

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

4. ordered or delivered by a Christian Science practitioner;

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

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

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

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

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

   This exclusion does not apply to mammography testing.

Reproduction

1. The following treatment-related services:

   - Cryo-preservation and other forms of preservation of reproductive materials except as described under Infertility.
   - Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
   - Donor services and non-medical costs of oocyte or sperm donation such as donor agency fees.
   - Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes.
   - Natural cycle insemination in the absence of sexual dysfunction or documented congenital or acquired cervical disease or mild to moderate male factor..
   - Ovulation predictor kits.

2. The following services related to Gestational Carrier or Surrogate:

   - Fees for the use of a Gestational Carrier or Surrogate.
   - Insemination costs of Surrogate or transfer embryo to Gestational Carrier.
   - Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.

3. The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):

- Donor eggs – The cost of donor eggs, including medical costs related to donor stimulation and egg retrieval. This exclusion may not apply to certain procedures related to Assisted Reproductive Technologies (ART) as described under Infertility Services including the cost for fertilization (in vitro fertilization or intracytoplasmic sperm injection), embryo culture, and embryo transfer.
- Donor sperm – The cost of procurement and storage of donor sperm. This exclusion may not apply to certain insemination procedures as described under Infertility Services including thawing and insemination.

4. The reversal of voluntary sterilization.
5. Health care services and related expenses for surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).
6. In vitro fertilization that is not an Assisted Reproductive Technology for the treatment of Infertility.
7. Artificial reproductive treatments done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.
8. Infertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation).
9. Infertility treatment following unsuccessful reversal of voluntary sterilization.
10. Infertility Treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis; vasectomy reversal/vasovasostomy or vasoepididymostomy).

Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB)*;
2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;
3. while on active military duty; and
4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

Transplants

1. health services for organ and tissue transplants, except as identified under *Transplantation Services* in Section 6*, Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;

2. health services for transplants involving animal organs.

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

Travel

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

2. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Provider may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 6, *Additional Coverage Details*.

Types of Care

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care;

2. Domiciliary Care, as defined in Section 14, *Glossary;*

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

4. Private Duty Nursing;

5. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 6, *Additional Coverage Details*;

6. rest cures;

7. services of personal care attendants;

8. work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

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

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

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

   - for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or

- for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

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

4. eye exercise or vision therapy; and

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

All Other Exclusions

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

2. charges for:

   - missed appointments;
   - room or facility reservations;
   - completion of claim forms; or
   - record processing.

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

4. diagnostic tests that are:

   - delivered in other than a Physician's office or health care facility; and
   - self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;

5. expenses for health services and supplies:

   - that do not meet the definition of a Covered Health Service in Section 14, *Glossary*;
   - that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;
   - that are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends. This exclusion does not apply to health services covered under *Extended Coverage for Total Disability* in *Section 12: When Coverage Ends.*;
   - for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan;
   - that exceed Eligible Expenses or any specified limitation in this SPD;
   - for which a non-Network provider waives the Copay, Annual Deductible or Coinsurance amounts;

6. foreign language and sign language services;

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

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

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

9. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

   - required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration;
   - conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*;
   - related to judicial or administrative proceedings or orders; or
   - required to obtain or maintain a license of any type.

SECTION 9 - CLAIMS PROCEDURES

What this section includes:

- How Network and non-Network claims work; and
- What to do if your claim is denied, in whole or in part.

Network Benefits

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

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

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on your ID card.

Prescription Drug Benefit Claims

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

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

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

How To File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the toll-free number on your ID card or contacting City of Tampa. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

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

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

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

The above information should be filed with us at the address on your ID card. When filing a claim for Outpatient Prescription Drug Benefits, submit your claim to the pharmacy benefit manager claims address noted on your ID card.

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

Payment of Benefits

Except as required by the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)*, you may not assign, transfer, or in any way convey your Benefits under the Plan or any cause of action related to your Benefits under the Plan to a provider or to any other third party. Nothing in this Plan shall be construed to make the Plan, Plan Sponsor, or Claims Administrator or its affiliates liable for payments to a provider or to a third party to whom you may be liable for payments for Benefits.

The Plan will not recognize claims for Benefits brought by a third party. Also, any such third party shall not have standing to bring any such claim independently, as a Covered Person or beneficiary, or derivatively, as an assignee of a Covered Person or beneficiary.

References herein to "third parties" include references to providers as well as any collection agencies or third parties that have purchased accounts receivable from providers or to whom accounts receivables have been assigned.

As a matter of convenience to a Covered Person, and where practicable for the Claims Administrator (as determined in its sole discretion), the Claims Administrator may make payment of Benefits directly to a provider.

Any such payment to a provider:

- is NOT an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits; and

- is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
- shall NOT estop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan's obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan), pursuant to *Refund of Overpayments* in *Section 10: Coordination of Benefits*.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which UnitedHealthcare makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 14, *Glossary* for the definition of Explanation of Benefits.

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

Claim Denials and Appeals

If Your Claim is Denied

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

How to Appeal a Denied Claim

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

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

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

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- urgent care request for Benefits;
- pre-service request for Benefits;
- post-service claim; or
- concurrent claim.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your health plan ID card. Generally, an urgent situation is when your life or health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your claim or appeal.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

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

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine their claim and/or appeals file(s). Covered Persons may also submit evidence, opinions and comments as part of the internal claims review process. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor. Any Covered Person will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required, with: (i) any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim; and, (ii) a reasonable opportunity for any Covered Person to respond to such new evidence or rationale.

External Review Program

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

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

- Clinical reasons.
- The exclusions for Experimental or Investigational Services or Unproven Services.
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

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

An external review request should include all of the following:

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

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

- A standard external review.
- An expedited external review.

Standard External Review

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

- A preliminary review by us of the request.
- A referral of the request by us to the *IRO*.
- A decision by the *IRO*.

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

- Is or was covered under the Policy at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that we may process the request.

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

The IRO will notify you in writing of the request's eligibility and acceptance for external review and if necessary, for any additional information needed to conduct the external review. You will generally have to submit the additional information in writing to the IRO within ten business days following the date you receive the *IRO*'s request for the additional information. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

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

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

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

Upon receipt of a *Final External Review Decision* reversing our determination, UnitedHealthcare will immediately provide coverage or payment for the Benefit claim at issue in accordance with the terms and conditions of the Policy, and any applicable law regarding plan remedies. If the *Final External Review Decision* agrees with UnitedHealthcare's determination the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the

review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

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

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

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

- Is or was covered under the Policy at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that we may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an *IRO* in the same manner UnitedHealthcare utilizes to assign standard external reviews to *IRO*s. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned *IRO* electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

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

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

Timing of Appeals Determinations

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

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services, as defined in Section 14, *Glossary*;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

Please note that the decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Claims Administrator's decision letter to you.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours**
You must then provide completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of additional information required
UnitedHealthcare must notify you of the benefit determination within:	**72 hours**
If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care request for Benefits.

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide completed request for Benefits information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial request for Benefits is complete, within:	**15 days**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

*UnitedHealthcare may require a one-time extension for the initial claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Plan.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**

Post-Service Claims	
Type of Claim or Appeal	**Timing**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Concurrent Care Claims

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

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

Limitation of Action

You cannot bring any legal action against City of Tampa or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against City of Tampa or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against City of Tampa or the Claims Administrator.

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

SECTION 10 - COORDINATION OF BENEFITS (COB)

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Plan will be coordinated with those of any other plan that provides benefits to you.

When Does Coordination of Benefits Apply?

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

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The Secondary Plan may determine its benefits based on the benefits paid by the Primary Plan. How much this Plan will reimburse you, if anything, will also depend in part on the Allowable Expense. The term, "Allowable Expense," is further explained below.

What Are the Rules for Determining the Order of Benefit Payments?

Order of Benefit Determination Rules

The order of benefit determination rules determine whether this Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits.

- **Primary Plan.** The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- **Secondary Plan.** The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.

B. When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.

C. Each Plan determines its order of benefits using the first of the following rules that apply:

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

2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

   a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
      (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
   b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
      (1) If a court decree states that one of the parents is responsible for the dependent 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 responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect

to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(2) 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 subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

a) The Plan covering the Custodial Parent.
b) The Plan covering the Custodial Parent's spouse.
c) The Plan covering the non-Custodial Parent.
d) The Plan covering the non-Custodial Parent's spouse.

For purpose of this section, Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

c) 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 subparagraph a) or b) above as if those individuals were parents of the child.

d) (i) 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 paragraph (5) applies.
(ii) 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 subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on

the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

How Are Benefits Paid When This Plan is Secondary?

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid based on the Allowable expense.
- The Plan pays the entire difference between the Allowable Expense and the amount paid by the Primary Plan, as long as this amount is not more than the Plan would have paid had it been the only plan involved.

You will be responsible for any applicable Copayment, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the Allowable Expense.

How is the Allowable Expense Determined when this Plan is Secondary?

Determining the Allowable Expense If this Plan is Secondary

What is an Allowable Expense? For purposes of COB, an Allowable Expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When the provider is a Network provider for both the Primary Plan and this Plan, the Allowable Expense is the Primary Plan's network rate. When the provider is a network provider for the Primary Plan and a non-Network provider for this Plan, the Allowable Expense is the Primary Plan's network rate. When the provider is a non-Network provider for the Primary Plan and a Network provider for this Plan, the Allowable Expense is the reasonable and customary charges allowed by the Primary Plan. When the provider is a non-Network provider for both the Primary Plan and this Plan, the Allowable Expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When this Plan is Secondary to Medicare".

What is Different When You Qualify for Medicare?

Determining Which Plan is Primary When You Qualify for Medicare

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare).
- Individuals with end-stage renal disease, for a limited period of time.
- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When this Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the Allowable Expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the Allowable Expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the Allowable Expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from an Opt-out provider or one that does not participate in the Medicare program or a provider who does not accept assignment of Medicare benefits, Benefits will be paid on a secondary basis under this Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience the Claims Administrator will treat the provider's billed charges for covered services as the Allowable Expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated Crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on your ID card.

Right to Receive and Release Needed Information?

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

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

Does This Plan Have the Right of Recovery?

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor-funded benefit plans, including this Plan. The Plan Sponsor also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, the Claims Administrator reserves the right to recover the excess amount from the provider pursuant to Refund of Overpayments, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by you, but all or some of the expenses were not paid by you or did not legally have to be paid by you.

- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.

If the refund is due from you and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for you that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payment in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will either:

- equal the amount of the required refund, or
- if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan.

The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this *Subrogation and Reimbursement* section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation – Example
Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement – Example
Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- The Plan Sponsor in a workers' compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.

- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or injuries.
  - Making court appearances.
  - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-

Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The

obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the employee, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover Benefits it has paid on you or your Dependent's behalf that were:

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.
- Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.
- If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- Require that the overpayment be returned when requested.
- Reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:

- Circumstances that cause coverage to end;
- Extended coverage; and
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

When your coverage ends, City of Tampa will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

Your coverage under the Plan will end on the earliest of:

- the last day of the month your employment with the Group ends;
- the date the Plan ends;
- the last day of the month you stop making the required contributions;
- the last day of the month you are no longer eligible;
- the last day of the month UnitedHealthcare receives written notice from City of Tampa to end your coverage, or the date requested in the notice, if later; or
- the last day of the month you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the last day of the month you stop making the required contributions;
- the last day of the month UnitedHealthcare receives written notice from City of Tampa to end your coverage, or the date requested in the notice, if later;
- last day of the calendar month in which the child is 18 months of age for a newborn child of an enrolled Dependent;
- the last day of the month for any other enrolled Dependent child who reaches the limiting age of 26 and no longer qualifies as a Dependent under this Plan;
- the end of the year for any other enrolled Dependent child who reaches the limiting age of 30 and no longer qualifies as a Dependent under this Plan; or

- the last day of the month your Dependents no longer qualify as Dependents under this Plan for reasons other than age.
- The last day of the month your Spouse no longer qualifies as a Dependent under this Plan.

Other Events Ending Your Coverage

The Plan will provide at least thirty days' prior written notice to you that your coverage will end on the date identified in the notice if you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

Note: If UnitedHealthcare and City of Tampa find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact City of Tampa has the right to demand that you pay back all Benefits City of Tampa paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical handicap or disability;
- the child depends mainly on you for support;
- you provide to City of Tampa proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age; and
- you provide proof, upon City of Tampa's request, that the child continues to meet these conditions.

The proof might include medical examinations at City of Tampa's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

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

Extended Coverage for Students

Coverage for an enrolled Dependent child who is a Student at a post-secondary school and who needs a medically necessary leave of absence will be extended until the earlier of the following:

- one year after the medically necessary leave of absence begins; or

- the date coverage would otherwise terminate under the Plan.

Coverage will be extended only when the enrolled Dependent is covered under the Plan because of Student status at a post-secondary school immediately before the medically necessary leave of absence begins.

Coverage will be extended only when the enrolled Dependent's change in Student status meets all of the following requirements:

- the enrolled Dependent is suffering from a serious Sickness or Injury;
- the leave of absence from the post-secondary school is medically necessary, as determined by the enrolled Dependent's treating Physician; and
- the medically necessary leave of absence causes the enrolled Dependent to lose Student status for purposes of coverage under the Plan.

A written certification by the treating Physician is required. The certification must state that the enrolled Dependent child is suffering from a serious Sickness or Injury and that the leave of absence is medically necessary.

For purposes of this extended provision, the term "leave of absence" shall include any change in enrollment at the post-secondary school that causes the loss of Student status.

Extended Coverage for Total Disability

If a Covered Person has a Total Disability on the date their coverage under the Plan ends, their Benefits will not end automatically. The Plan will temporarily extend coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of:

- the Total Disability ends; or
- twelve months from the date coverage would have ended.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, *Glossary*.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if City of Tampa is subject to the provisions of COBRA.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- an Employee;
- an Employee's enrolled Dependent, including with respect to the Employee's children, a child born to or placed for adoption with the Employee during a period of continuation coverage under federal law; or
- an Employee's former Spouse.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
City of Tampa files for bankruptcy under Title 11, United States Code.[2]	36 months	36 months[3]	36 months[3]

[1]Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)

who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

[2]This is a qualifying event for any Retired Employee and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

[3]From the date of the Employee's death if the Employee dies during the continuation coverage.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Employee and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during Open Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2, *Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide City of Tampa with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If an Employee qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Employee must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Employee will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

When COBRA Ends

COBRA coverage will end, before the maximum continuation period, on the earliest of the following dates:

- the date, after electing continuation coverage, that coverage is first obtained under any other group health plan;
- the date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare;
- the date coverage ends for failure to make the first required premium payment (premium is not paid within 45 days);
- the date coverage ends for failure to make any other monthly premium payment (premium is not paid within 30 days of its due date);
- the date the entire Plan ends; or
- the date coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Uniformed Services Employment and Reemployment Rights Act

An Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Employee and the Employee's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on an Employee's behalf. If an Employee's Military Service is for a period of time less than 31 days, the Employee may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

An Employee may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Employee's absence from work; or
- the day after the date on which the Employee fails to apply for, or return to, a position of employment.

Regardless of whether an Employee continues health coverage, if the Employee returns to a position of employment, the Employee's health coverage and that of the Employee's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Employee or the Employee's eligible Dependents in connection with this

reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children;
- Your relationship with UnitedHealthcare and City of Tampa;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan; and
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and City of Tampa

In order to make choices about your health care coverage and treatment, City of Tampa believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- City of Tampa and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions;
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD); and
- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

City of Tampa and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. City of Tampa and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. City of Tampa and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The Claims Administrator has agreements in place that govern the relationships between it and City of Tampa and Network providers, some of which are affiliated providers. Network providers enter into agreements with the Claims Administrator to provide Covered Health Services to Covered Persons.

City of Tampa and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, City of Tampa and UnitedHealthcare arrange for health care providers to participate in a Network and administer payment of Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not City of Tampa's employees nor are they employees of UnitedHealthcare. City of Tampa and UnitedHealthcare are not responsible for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

City of Tampa is solely responsible for:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the service fee to UnitedHealthcare.
- The funding of Benefits on a timely basis.
- Notifying you of the termination or modifications to the Plan.

When the Plan Sponsor establishes the Plan to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("*ERISA*"), *29 U.S.C. §1001 et seq.*, the Claims Administrator is not the plan administrator or named fiduciary of the benefit plan, as those terms are used in *ERISA*. If you have questions about your welfare benefit plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under *ERISA*, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own provider;
- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;
- must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and
- must decide with your provider what care you should receive.

Interpretation of Benefits

City of Tampa and UnitedHealthcare have the sole and exclusive discretion to do all of the following:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD, the Schedule of Benefits and any Addendums, SMMs and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

City of Tampa and UnitedHealthcare may delegate this discretionary authority to other persons or entities including Claims Administrator's affiliates that may provide services in regard to the administration of the Plan. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

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

Information and Records

City of Tampa and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. City of Tampa and UnitedHealthcare may request additional information from you to decide your claim for Benefits. City of Tampa and UnitedHealthcare will keep this information confidential. City of Tampa and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

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

City of Tampa and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as City of Tampa is required to do by law or regulation. During and after the term of the Plan, City of Tampa and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

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

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

In some cases, City of Tampa and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- a practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. The applicableCopayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up

services are included in the bundled payment. You may receive some Covered Health Services that are not considered part of the inclusive bundled payment and those Covered Health Services would be subject to the applicable Copayment and/or Coinsurance as described in your *Schedule of Benefits*.

The Claims Administrator uses various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the telephone number on your ID card. The Claims Administrator can advise whether your Network provider is paid by any financial incentive, including those listed above.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to participate is yours alone but City of Tampa recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on your ID card if you have any questions. Additional information may be found in Section 7, *Clinical Programs and Resources*.

Rebates and Other Payments

City of Tampa and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. City of Tampa and UnitedHealthcare may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Copays and/or Coinsurance.

Workers' Compensation Not Affected

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

Future of the Plan

Although the Group expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Group's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code, or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Group does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Group decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Group and others as may be required by any applicable law.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

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

  Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in UnitedHealthcare's Network through UnitedHealthcare's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

UnitedHealthcare may apply a reimbursement methodology established by *OptumInsight* and/or a third party vendor, which is based on *CMS* coding principles, to determine appropriate reimbursement levels for Emergency Health Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use a comparable methodology(ies). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable methodology.

SECTION 14 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Addendum – any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Air Ambulance – medical transport by rotary wing Air Ambulance or fixed wing Air Ambulance helicopter or airplane as defined in *42 CFR 414.605*.

Alternate Facility – a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- surgical services;
- Emergency Health Services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance-Related and Addictive Disorders Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility).

Ancillary Services – items and services provided by non-Network Physicians at a Network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by a non-Network Physician when no other Network Physician is available.

Amendment – any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) – the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in Section 5, *Plan Highlights*.

Assisted Reproductive Technology (ART) – the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs, and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- in vitro fertilization (IVF);
- gamete intrafallopian transfer (GIFT);
- pronuclear stage tubal transfer (PROST);
- tubal embryo transfer (TET); and
- zygote intrafallopian transfer (ZIFT).

Autism Spectrum Disorders – a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Bariatric Resource Services (BRS) – a program administered by UnitedHealthcare or its affiliates made available to you by City of Tampa. The BRS program provides:

- specialized clinical consulting services to Employees and enrolled Dependents to educate on obesity treatment options; and
- access to specialized Network facilities and Physicians for obesity surgery services.

Benefits – Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Body Mass Index (BMI) – a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

BMI – see Body Mass Index (BMI).

Cancer Resource Services (CRS) – a program administered by UnitedHealthcare or its affiliates made available to you by City of Tampa. The CRS program provides:

- specialized consulting services, on a limited basis, to Employees and enrolled Dependents with cancer;
- access to cancer centers with expertise in treating the most rare or complex cancers; and
- education to help patients understand their cancer and make informed decisions about their care and course of treatment.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

CHD – see Congenital Heart Disease (CHD).

Claims Administrator – UnitedHealthcare (also known as United HealthCare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial – a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance – the charge, stated as a percentage of Eligible Expenses or the Recognized Amount when applicable, that you are required to pay for certain Covered Health Services as described in Section 3, How the Plan Works and Section 15, Outpatient Prescription Drugs.

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

Congenital Heart Disease (CHD) – any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- be passed from a parent to a child (inherited);
- develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; or
- have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Copayment (or Copay) – the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works' and* Section 15, *Outpatient Prescription Drugs*.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense or the Recognized Amount when applicable.

Cosmetic Procedures – procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function like breathing.

Cost-Effective – the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products, which UnitedHealthcare determines to be:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Service in this SPD under Section 5, *Plan Highlights* and Section 6, *Additional Coverage Details* and Section 15, *Outpatient Prescription Drugs*.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*.
- Not otherwise excluded in this SPD under Section 8, *Exclusions and Limitations* or Section 15, *Outpatient Prescription Drugs*.

Covered Person – either the Employee or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

CRS – see Cancer Resource Services (CRS).

Custodial Care – services that do not require special skills or training and that:

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible – see Annual Deductible.

Definitive Drug Test - test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug.

Dependent – an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

Designated Network Benefits – for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for the Covered Health Services provided by a Physician or other provider has been identified as a Designated provider.

Refer to Section 5, *Plan Highlights*, to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with UnitedHealthcare, or with an organization contracting on UnitedHealthcare's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- UnitedHealthcare has identified through UnitedHealthcare's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting UnitedHealthcare at **www.myuhc.com** or the telephone number on your ID card.

Diabetes-related Condition – a diagnosis of diabetes or pre-diabetes based on a Covered Person's claim history or completion of a valid diagnosis verification by the Covered Person's Physician or a fasting blood glucose level greater than 99.

DME – see Durable Medical Equipment (DME).

Domestic Partner – an individual of the same or opposite sex with whom you have established a domestic partnership as described below.

A domestic partnership is a relationship between an Employee and one other person of the same or opposite sex. Both persons must:

- not be so closely related that marriage would otherwise be prohibited;
- not be legally married to, or the Domestic Partner of, another person under either statutory or common law;
- be at least 18 years old;
- live together and share the common necessities of life;
- be mentally competent to enter into a contract; and
- be financially interdependent

The Employee and Domestic Partner must jointly sign an affidavit of domestic partnership provided by City of Tampa upon your request.

Domiciliary Care – living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) – medical equipment that is all of the following:

- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not disposable;

- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

Eligible Expenses – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in Section 3, *How the Plan Works*.

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

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

Emergency – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Health Services – with respect to an Emergency:

- An appropriate medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department*)* that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*, or as would be required under such section

if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3))*.

- Emergency Health Services include items and services otherwise covered under the Plan when provided by a non-Network provider or facility (regardless of the department of the Hospital in which the items are services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original Emergency unless the following conditions are met:

    a. The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.

    b. The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.

    c. The patient is in such a condition, as determined by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law.

    d. The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.

    e. Any other conditions as specified by the Secretary.

  The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

Employee – a full-time Employee of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. An Employee must live and/or work in the United States.

Employer – City of Tampa.

EOB – see Explanation of Benefits (EOB).

Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;

- subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational); or
- the subject of an ongoing Clinical Trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.

If you are not a participant in a qualifying Clinical Trial as described under Section 6, *Additional Coverage Details,* and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) – a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

Full-time Student – a person who is enrolled in and attending a recognized course of study or training at one of the following:

- An accredited high school.
- An accredited college or university.
- A licensed vocational school, technical school, cosmetology school, automotive school or similar training school.

Student status is determined in accordance with the standards set forth by the educational institution. You are no longer a Student at the end of the calendar year during which you graduate or otherwise cease to be enrolled and in attendance at the institution.

You continue to be a Student during periods of regular vacation established by the institution. If you do not continue as a Student immediately following the period of vacation, the Student designation will end as described above.

Gender Dysphoria - A disorder characterized by the diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Testing - exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier - a Gestational Carrier is a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

Group – City of Tampa.

Health Statement(s) – a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

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

Hospital – an institution, operated as required by law, which is:

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

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a Skilled Nursing Facility, convalescent home or similar institution.

Independent Freestanding Emergency Department – a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable law; and
- Provides Emergency Health Services.

Infertility - A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or Therapeutic Donor Insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women age 35 years or older.

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

Inpatient Rehabilitation Facility – a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

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

Intensive Behavioral Therapy (IBT) – outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI)*.

Intensive Outpatient Treatment - a structured outpatient treatment program.

- For Mental Health Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health.

Intermittent Care – skilled nursing care that is provided or needed either:

- fewer than seven days each week; or
- fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Kidney Resource Services (KRS) – a program administered by UnitedHealthcare or its affiliates made available to you by City of Tampa. The KRS program provides:

- specialized consulting services to Employees and enrolled Dependents with ESRD or chronic kidney disease;
- access to dialysis centers with expertise in treating kidney disease; and
- guidance for the patient on the prescribed plan of care.

Manipulative Treatment – the therapeutic application of chiropractic and/or manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medicaid – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary - health care services that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are

available to Covered Persons on **www.myuhc.com** or by calling the number on your ID card, and to Physicians and other health care professionals on **www.UHCprovider.com**.

Medicare – Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services –Services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Administrator – the organization or individual designated by City of Tampa who provides or arranges Mental Health and Substance-Related and Addictive Disorders Services under the Plan.

Mental Illness – those mental health or psychiatric diagnostic categories listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Neonatal Resource Services (NRS) - a program administered by UnitedHealthcare or its affiliates made available to you by City of Tampa. The NRS program provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to help manage NICU admissions.

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

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, *Plan Highlights* for details about how Network Benefits apply.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

Non-Medical 24-Hour Withdrawal Management - An organized residential service, including those defined in American Society of Addiction Medicine (ASAM), providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

Non-Network Benefits - description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, *Plan Highlights* for details about how Non-Network Benefits apply.

Open Enrollment – the period of time, determined by City of Tampa, during which eligible Employees may enroll themselves and their Dependents under the Plan. City of Tampa determines the period of time that is the Open Enrollment period.

Out-of-Pocket Maximum – the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment – a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Personal Health Support – programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Personal Health Support Nurse – the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Products – U.S. Food and Drug Administration (FDA)-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

Physician – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

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

Plan – The City of Tampa Medical Plan.

Plan Administrator – City of Tampa or its designee.

Plan Sponsor – City of Tampa.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with the above.

Presumptive Drug Test - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

Primary Physician – a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing – nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or a home setting when any of the following are true:

- services exceed the scope of Intermittent Care in the home.
- skilled nursing resources are available in the facility;
- the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose; or
- the service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.

Recognized Amount – the amount which Copayment, Coinsurance and applicable deductible, is based on for the below Covered Health Services when provided by non-Network providers.

- Non-Network Emergency Health Services.
- Non-Emergency Covered Health Services received at certain Network facilities by non-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Service Act*. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

The amount is based on either:

1) An *All Payer Model Agreement* if adopted,
2) State law, or
3) The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by a non-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Services were determined based upon an Eligible Expense.

Reconstructive Procedure – a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment – treatment in a facility which provides a program of effective Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The Facility meets all of the following requirements:

- it is established and operated in accordance with applicable state law for Residential Treatment programs;
- it provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Administrator;
- it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- it provides at least the following basic services in a 24-hour per day, structured milieu:
  - room and board;
  - evaluation and diagnosis;
  - counseling; and
  - referral and orientation to specialized community resources.

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

Retired Employee – an Employee who retires while covered under the Plan.

Secretary – as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260).*

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

Shared Savings Program – a program in which UnitedHealthcare may obtain a discount to a non-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-Network provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and any applicable deductible would still apply to the reduced charge. Sometimes Plan provisions or administrative practices supersede the scheduled rate, and a different rate is determined by UnitedHealthcare.

This means, when contractually permitted, the Plan may pay the lesser of the Shared Savings Program discount or an amount determined by the Claims Administrator, such as:

- A percentage of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market.
- An amount determined based on available data resources of competitive fees in that geographic area.
- A fee schedule established by a third party vendor.
- A negotiated rate with the provider.

In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

Sickness – physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness or substance-related and addictive disorder, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care – skilled nursing, teaching, and rehabilitation services when:

- they are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- a Physician orders them;
- they are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility – a nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spouse – an individual to whom you are legally married or a Domestic Partner as defined in this section.

Substance-Related and Addictive Disorders Services - Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg the surrogate is biologically (genetically) related to the child.

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a *CMS* defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Therapeutic Donor Insemination (TDI) - Insemination with a donor sperm sample for the purpose of conceiving a child.

Total Disability – an Employee's inability to perform all substantial job duties because of physical or mental impairment, or a Dependent's or retired person's inability to perform the normal activities of a person of like age and gender.

Transitional Living – Mental Health Services/Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision , including those defined in American Society of Addiction Medicine (ASAM) criteria, that are either:

- sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery; or
- supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

UnitedHealth Premium Program℠ (Tier 1)– a program that identifies Network Physicians or facilities that have been designated as a UnitedHealth Premium Program℠ Physician or facility for certain medical conditions.

To be designated as a UnitedHealth Premium℠ provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium Program℠ Physician or facility.

Unproven Services – health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com**.

Please note:

If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care – care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

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

SECTION 15 - PRESCRIPTION DRUGS

What this section includes:

- Benefits available for Prescription Drugs;
- How to utilize the retail and mail order service for obtaining Prescription Drugs;
- Any benefit limitations and exclusions that exist for Prescription Drugs; and
- Definitions of terms used throughout this section related to the Prescription Drug Plan.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List (PDL) the Prescription Drug Product is listed. Refer to the Outpatient Prescription Drug Schedule of Benefits for applicable Copayments and/or Coinsurance requirements.

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

What You Must Pay

You are responsible for paying the applicable Copayment and/or Coinsurance described in the *Payment Information - Outpatient Prescription Drugs* table or *Schedule of Benefits - Outpatient Prescription Drugs*, in addition to any Ancillary Charge or Therapeutically Equivalent Charge.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is Chemically Equivalent.

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

- Certain coupons or offers from pharmaceutical manufacturers. You may access information on which coupons or offers are not permitted through the Internet at **www.myuhc.com** or by calling the telephone number on your ID card.
- The difference between the Out-of-Network Reimbursement Rate and a non-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and UnitedHealthcare contracted rates (Prescription Drug Charge) will not be available to you.

Payment Terms and Features - Outpatient Prescription Drugs

Prescription Drug Product Coverage Highlights

The table below provides an overview of the Plan's Prescription Drug Product coverage. It includes Copay amounts that apply when you have a prescription filled at a Network or non-Network Pharmacy. For detailed descriptions of your Benefits, refer to *Retail* and *Mail Order* in this section.

If a Brand-name Drug Is or Becomes Available as a Generic

If a Brand-name Prescription Drug is available or becomes available as a Generic drug, the tier placement of the Brand-name Prescription Drug Product may change and an Ancillary Charge may apply. As a result, your Copay may change. You will pay the Tier 1 Copay as well as an Ancillary Charge if the Brand is filled when a Generic is available.

Notification Requirements

Before certain Prescription Drug Products are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to notify UnitedHealthcare or its designee. The reason for notifying UnitedHealthcare or its designee is to determine if the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service as defined by the Plan.
- It is not an Experimental or Investigational or Unproven Service, as defined in Section 14, *Glossary*.

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

Network Pharmacy Notification

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

Non-Network Pharmacy Notification

When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician are responsible for notifying UnitedHealthcare as required.

If UnitedHealthcare is not notified before the Prescription Drug Product is dispensed, you may pay more for that Prescription Drug order or refill. You will be required to pay for the Prescription Drug at the time of purchase. The Prescription Drug Products requiring notification are subject to UnitedHealthcare's periodic review and modification. You may determine whether a particular Prescription Drug Product requires notification through the Internet at **www.myuhc.com** or by calling the telephone number on your ID card.

If UnitedHealthcare is not notified before the Prescription Drug Product is dispensed, you can ask Unitedhealthcare to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from the Plan as described in Section 9, *Claims Procedures*.

When you submit a claim on this basis, you may pay more because you did not obtain notification from UnitedHealthcare before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy), less the required Copayment and/or Coinsurance and any Deductible that applies.

To determine if a Prescription Drug Product requires notification, either visit **www.myuhc.com** or call the number on your ID card. The Prescription Drug Products requiring notification are subject to UnitedHealthcare's periodic review and modification.

Benefits may not be available for the Prescription Drug Product after UnitedHealthcare reviews the documentation provided and determines that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

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

Benefit Information for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy.

Covered Health Services[1,3]	**Percentage of Prescription Drug Charge Payable by the Plan (Per Prescription Order or Refill):**	**Percentage of Out-of-Network Reimbursement Rate Payable by the Plan (Per Prescription Order or Refill):**
	Network	**Non-Network**
Retail - up to a 31-day supply[2]	100% after you pay a:	
■ tier-1[4]	$30 Copay	$30 Copay
■ tier-2[4]	$60 Copay	$60 Copay
■ tier-3	$90 Copay	$90 Copay
■ tier 4	25%	25%
Mail order - up to a 90-day supply[2]	100% after you pay a:	
■ tier-1[4]	$60 Copay	Not Covered
■ tier-2[4]	$120 Copay	Not Covered
■ tier-3	$180 Copay	Not Covered
■ tier-4	25%	Not Covered
Growth Hormone Therapy 100% after you pay 30% of the Prescription Drug Cost. Any combination of retail Network pharmacy, retail Non-Network pharmacy and Mail Order Network Pharmacy Benefits for growth hormone therapy is limited to $10,000 per Covered Person per calendar year.		

Covered Health Services[1,3]	Percentage of Prescription Drug Charge Payable by the Plan (Per Prescription Order or Refill):	Percentage of Out-of-Network Reimbursement Rate Payable by the Plan (Per Prescription Order or Refill):
	Network	Non-Network
Maximum Annual Plan Benefit for Infertility $5,000 per Covered Person per Calendar Year during the entire time you are covered under the Plan combined with any medical coverage under the Plan.		

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

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

[3]You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

[4]Certain medications that are commonly prescribed to people with a Diabetes-related Condition that are in tier-1 or tier-2 may have a reduced or waived Copay. See *Enhanced Benefits* in Section 5, *Plan Highlights* for additional information.

Note: The Coordination of Benefits provision described in Section 10, *Coordination of Benefits (COB)* does not apply to covered Prescription Drugs as described in this section. Prescription Drug Benefits will not be coordinated with those of any other health coverage plan.

Enhanced Benefits

In addition to the Benefits listed above, City of Tampa through UnitedHealthcare also offer a way for individuals who have a Diabetes-related Condition to receive a reduction or waiver of Copays. In order to receive these enhanced Benefits you must meet all of the requirements based on nationally recognized standards of care identified. Your participation is completely voluntary; however, if you do not participate in the programs or meet the criteria identified your Benefits will be paid at the levels described in the above tables of this section. For a complete description of the conditions, criteria and Benefits that apply to the enhanced Benefits, refer to the table "Enhanced Benefits" in Section 5, *Plan Highlights*. You may also access information on the list of Prescription Drug Products that are subject to the reduced Copay through the Internet at **www.myuhc.com** or by calling the customer service number on your ID card.

Identification Card (ID Card) – Network Pharmacy

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

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

You may seek reimbursement from the Plan as described in Section 9, *Claims Procedures,* under the heading, *How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Submit your claim to:

Optum Rx
P.O. Box 29077
Hot Springs, AR 71903

Benefit Levels

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

The Plan pays Benefits at different levels for tier-1, tier-2, tier-3 and tier-4 Prescription Drugs. All Prescription Drugs covered by the Plan are categorized into these four tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug, depending on its tier assignment. Since the PDL may change periodically, you can visit **www.myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card for the most current information.

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

- Tier-1 is your lowest Copay option. For the lowest out-of-pocket expense, you should consider tier-1 drugs if you and your Physician decide they are appropriate for your treatment.
- Tier-2 is your middle Copay option. Consider a tier-2 drug if no tier-1 drug is available to treat your condition.
- Tier-3 and Tier-4 are your highest Copay /Coinsurance option. The drugs in tier-3 and tier-4 are usually more costly. Sometimes there are alternatives available in tier-1 or tier-2.

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

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

- the applicable Copay and/or Coinsurance;
- the Network Pharmacy's Usual and Customary Charge for the Prescription Drug; or

The Prescription Drug Charge for that Prescription Drug Product.

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

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

Retail

The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto **www.myuhc.com**.

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

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

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

Mail Order

The mail order service may allow you to purchase up to a 90-day supply of a covered maintenance drug through the Optum Rx Mail Order Pharmacy. Maintenance drugs help in the treatment of chronic illnesses, such as heart conditions, allergies, high blood pressure, and arthritis.

To use the mail order service, choose the method that works best for you:

1. Call (**800) 562-6223**, 24 hours a day, 7 days a week. Keep your medication name and dosage handy. You'll also need your Physician's name and phone number. Optum Rx will call your Physician to get a new prescription.

2. Mail your original prescription, payment and completed order form to the address listed on the form. Write your date of birth on each prescription.
3. Your Physician can call in your prescription to (**800) 791-7658** or fax it to (**800) 491-7997**. Faxed prescriptions will only be accepted from a Physician's office.

Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received. If you need an order form, or if you have any questions, you can reach UnitedHealthcare at the toll-free number on your ID card.

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

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

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

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

Benefits for Preventive Care Medications

Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined under *Glossary – Prescription Drugs*. You may determine whether a drug is a Preventive Care Medication through the internet at **www.myuhc.com** or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, UnitedHealthcare may direct you to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the Non-Network Benefit for that Prescription Drug Product.

Specialty Prescription Drug Products

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

Please see the Prescription Drug Glossary in this section for definitions of Specialty Prescription Drug and Designated Pharmacy.

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you will be subject to the Non-Network Benefit for that Specialty Prescription Drug Product.

Want to lower your out-of-pocket Prescription Drug costs?
Consider tier-1 Prescription Drugs, if you and your Physician decide they are appropriate.

Assigning Prescription Drug Products to the PDL

UnitedHealthcare's Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on UnitedHealthcare's behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are most cost effective for specific indications as compared to others, therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

The PDL Management Committee may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

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

Note: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access **www.myuhc.com** through the Internet or call the telephone number on your ID card for the most up-to-date tier status.

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

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

Prescription Drug Benefit Claims

For Prescription Drug Product claims procedures, please refer to Section 9, *Claims Procedures*.

Limitation on Selection of Pharmacies

If the Claims Administrator determines that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, you may be required to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date the Plan Administrator notifies you, the Claims Administrator will select a single Network Pharmacy for you.

Supply Limits

Some Prescription Drugs are subject to supply limits that may restrict the amount dispensed per prescription order or refill. To determine if a Prescription Drug has been assigned a maximum quantity level for dispensing, either visit **www.myuhc.com** or call the toll-free number on your ID card. Whether or not a Prescription Drug has a supply limit is subject to UnitedHealthcare's periodic review and modification.

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

If a Brand-name Drug Becomes Available as a Generic

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

Special Programs

City of Tampa and UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Maintenance Medication Program

If you require certain Maintenance Medications, UnitedHealthcare may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications.

Prescription Drug Products Prescribed by a Specialist Physician

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

Step Therapy

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

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

Rebates and Other Discounts

UnitedHealthcare and City of Tampa may, at times, receive rebates for certain drugs included on the PDL. As determined by UnitedHealthcare, the Plan may pass a portion of these rebates on to you. When rebates are passed on to you they may be taken into account in determining your Copayment and/or Coinsurance.

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

Coupons, Incentives and Other Communications

At various times, UnitedHealthcare may send mailings to you, your Physician or your pharmacy that communicate a variety of messages, including information about Prescription Drug Products. These communications may include offers that enable you, at your discretion, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Exclusions - What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed under Section 8, *Exclusions* also apply to this section. In addition, the following exclusions apply.

When an exclusion applies to only certain Prescription Drugs, you can access **www.myuhc.com** through the Internet or by calling the telephone number on your ID card for information on which Prescription Drugs are excluded.

Medications that are:

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

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

3. Pharmaceutical Products for which Benefits are provided in the medical (not in Section 15, *Prescription Drugs*) portion of the Plan; this includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

4. Compounded drugs that contain certain bulk chemicals. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.) Compounded drugs that are available as a similar commercially available Prescription Drug Product;

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

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

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

8. certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Claims Administrator's Prescription Drug List (PDL) Management Committee;

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

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

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

12. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision;

13. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision;

14. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by UnitedHealthcare. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

15. certain unit dose packaging of Prescription Drugs;

16. used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, as defined in Section 14, *Glossary*;

17. Medications used for cosmetic purposes;

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

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

19. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury.

20. A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and UnitedHealthcare may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

21. Certain Prescription Drug Product that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

22. Prescription Drug Products dispensed outside of the United States, except in an Emergency.

23. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

Glossary - Prescription Drugs

Ancillary Charge – a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Product Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product, and the Prescription Drug Product Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product. For Prescription Drug Products from non-Network Pharmacies, the Ancillary Charge is calculated as the difference between the Out-of-Network Reimbursement Rate or Maximum Allowable Cost (MAC) List price for non-Network Pharmacies for the Prescription Drug Product, and the Out-of-Network Reimbursement Rate or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product.

Brand-name - a Prescription Drug that is either:

- manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- identified by UnitedHealthcare as a Brand-name Drug based on available data resources including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by the Claims Administrator.

Designated Pharmacy – a pharmacy that has entered into an agreement with UnitedHealthcare or with an organization contracting on its behalf, to provide specific Prescription Drugs including, but not limited to, Specialty Prescription Drugs. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic – (Tier 1) Prescription Drug that is either:

- chemically equivalent to a Brand-name drug; or
- identified by UnitedHealthcare as a Generic Drug based on available data resources, including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by the Claims Administrator.

Maximum Allowable Amount - the maximum amount that should be paid for covered Prescription Drug Products in a Therapeutic Class. This amount is subject to UnitedHealthcare's periodic review and modification and varies by Therapeutic Class.

Maximum Allowable Cost (MAC) List – a list of Generic Prescription Drug Products that will be covered at a price level that UnitedHealthcare establishes. This list is subject to UnitedHealthcare's periodic review and modification.

Maintenance Medication – a Prescription Drug Product anticipated to be used for six months or more to treat or prevent a chronic condition. You may determine whether a Prescription Drug Product is a Maintenance Medication through the Internet at **www.myuhc.com** or by calling the telephone number on your ID card.

Network Pharmacy - a retail or mail order pharmacy that has:

- entered into an agreement with the Claims Administrator to dispense Prescription Drugs to Covered Persons;
- agreed to accept specified reimbursement rates for Prescription Drugs; and
- been designated by the Claims Administrator as a Network Pharmacy.

Out-of-Network Reimbursement Rate – the amount the Plan will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Out-of-Network Reimbursement Rate for a particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax.

PDL - see Prescription Drug List (PDL).

PDL Management Committee - see Prescription Drug List (PDL) Management Committee.

Prescription Drug Charge – the rate the Plan has agreed to pay UnitedHealthcare on behalf of its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug dispensed at a Network Pharmacy. The Prescription Drug Charge for a Generic Prescription Drug Product dispensed by a mail order Network Pharmacy, however, will be the Maximum Allowable Cost (MAC) List price which may be higher or lower than the rate UnitedHealthcare has agreed to pay the mail order Network Pharmacy. UnitedHealthcare establishes the Maximum Allowable Cost (MAC) List price. You may access the amount you will pay for a Brand-name or Generic Prescription Drug Product to be dispensed by a retail Network Pharmacy and/or a Mail Order Network Pharmacy through the Internet at **www.myuhc.com** or by calling the telephone number on your ID card. Depending upon your plan design, the amount you will pay may be a Copayment, Coinsurance or the Prescription Drug Charge.

Prescription Drug List (PDL) - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration*. This list is subject to periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug has been assigned by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto **www.myuhc.com**.

Prescription Drug List (PDL) Management Committee - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

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

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - Standard insulin syringes with needles.
  - Blood-testing strips - glucose.
  - Urine-testing strips - glucose.
  - Ketone-testing strips and tablets.
  - Lancets and lancet devices.
  - Insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets.
  - Glucose meters including continuous glucose monitors.
  - Certain vaccines/immunizations administered in a Network Pharmacy.
- Certain injectable medications administered in a Network Pharmacy.

Preventive Care Medications (PPACA Zero Cost Share) – the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Prescription Drug Deductible or Specialty Prescription Drug Annual Deductible) as required by applicable law under any of the following:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; or
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

For the purposes of this definition PPACA means Patient Protection and Affordable Care Act of 2010.

Specialty Prescription Drug - Prescription Drug that is generally high cost, self-injectable, oral or inhaled biotechnology drug used to treat patients with certain illnesses. Specialty Prescription Drugs include certain drugs for Infertility. For more information, visit **myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card.

Therapeutic Class – a group or category of Prescription Drug with similar uses and/or actions.

Therapeutic Class Charge - a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product that is dispensed at your or your provider's request is in a Therapeutic Class where we have determined a Maximum Allowable Amount. For Prescription Drug Products from Network Pharmacies, the Therapeutic Class Charge is calculated as the difference between the Prescription Drug Charge for Network Pharmacies for the Prescription Drug Product dispensed and the Maximum Allowable Amount for the Therapeutic Class. For Prescription Drug Products from non-Network Pharmacies, the Therapeutic Class Charge is calculated as the difference between the Out-of-Network Reimbursement Rate for the Prescription Drug Product dispensed and the Maximum Allowable Amount for the Therapeutic Class.

Therapeutically Equivalent – when Prescription Drugs have essentially the same efficacy and adverse effect profile.

Therapeutically Equivalent Charge –a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product that is dispensed at your or your provider's request is Therapeutically Equivalent to a Prescription Drug Product where UnitedHealthcare has determined a Maximum Allowable Amount. For Prescription Drug Products from Network Pharmacies, the Therapeutically Equivalent Charge is calculated as the difference between the Prescription Drug Charge for Network Pharmacies for the Prescription Drug Product dispensed and the Maximum Allowable Amount for the Therapeutically Equivalent Prescription Drug Product. For Prescription Drug Products from non-Network Pharmacies, the Therapeutically Equivalent Charge is calculated as the difference between the Out-of-Network Reimbursement Rate for the Prescription Drug Product dispensed and the Maximum Allowable Amount for the Therapeutically Equivalent Prescription Drug Product.

Usual and Customary Charge – the usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

SECTION 16 - HEALTH REIMBURSEMENT ACCOUNT PLAN - NUMBER 915199

This Section describes the healthcare expense reimbursement component of the Plan. It includes summaries of:

- What is a Health Reimbursement Account (HRA) Plan; Who is Eligible and How to Enroll; and How the HRA Plan Works;
- Health Incentives;
- New Hires And Adjustments For Status Changes;
- What Type of Expenses Qualify for Reimbursement from the HRA;
- Order of Accounts;
- What Happens to Remaining Balances in your HRA;
- HRA Claims Procedures; and
- HRA Administrative Information.

Notice to Employees

This Section of the Summary Plan Description (SPD) describes the Employer-sponsored Health Reimbursement Account (HRA) Plan.

City of Tampa has entered into an agreement with United Healthcare Services, Inc., Minnetonka, MN ("UnitedHealthcare") under which UnitedHealthcare will process eligible healthcare expense reimbursements through the HRA and provide certain other administrative services pertaining to the Plan. UnitedHealthcare does not insure the benefits described in this Section.

Quick Reference Box

- Member services and claim inquiries, use the Customer Service number on your ID card or call 1-800-331-0480;
- HRA Claims submittal address: Health Care Account Service Center, PO Box 981506, El Paso, TX 79998-1506; and
- Online assistance: **www.myuhc.com**.

Welcome - HRA

This Section of your Summary Plan Description (SPD) describes the Health Reimbursement Account (HRA) available to you and your eligible dependents enrolled in the Plan.

A Health Reimbursement Account is a financial account that allows City of Tampa to reimburse you for "qualified" health expenses paid by you, under the associated medical plan, to offset health care costs.

The HRA maximizes the value of your health care dollars, and allows you to become more engaged in managing health care spending. UnitedHealthcare offers several tools to help you make more informed health care decisions and manage your HRA account balance; refer to Section 6 - *Resources to Help You Stay Healthy* for information on health and well-being resources available to you, or visit **www.myuhc.com** for access to a treatment cost estimator. Once you spend your entire HRA balance, you are responsible for paying expenses as described in your SPD.

You can keep track of the funds in your HRA by going online to **www.myuhc.com**, by calling the toll-free number on your ID card or by checking your monthly member statement sent to you by UnitedHealthcare.

Please read this Section thoroughly to learn how the HRA component of the Plan works. If you have questions call the number on your ID card. Capitalized terms not otherwise defined in this Section have the meaning set forth in the SPD, Section 13 - *Glossary*.

What is a Health Reimbursement Account?

Health Reimbursement Accounts are "unfunded" accounts; otherwise known as a demand deposit account. City of Tampa is not required to prepay into it, instead, funds allocated to the HRA are made available to reimburse you for claims as they occur. All contributions allocated to your HRA are owned, controlled and payable solely from the general assets of City of Tampa. You are not permitted to make any contribution to the HRA, whether made on a pre-tax or after-tax basis. In addition:

- The HRA is established by City of Tampa and administered by UnitedHealthcare in accordance with applicable provisions of the Internal Revenue Service Code and associated guidance issued by the IRS/Treasury Department.
- City of Tampa determines which Internal Revenue Code 213d health expenses will be eligible for reimbursement through the HRA.
- Reimbursements of qualified medical expenses are tax-deductible for City of Tampa.
- There is no limit to the contributions City of Tampa can choose to allocate to your account.
- Employer contributions allocated to your HRA can be excluded from your gross income.
- City of Tampa will decide how to handle unused funds at the end of the plan year. Unused funds are not transferable if your employment with City of Tampa ends.
- The Plan offers a Health Incentive program with your HRA. The contribution amount to be allocated to your HRA upon completion of an activity has been determined by City of Tampa and depends on the number and type of activities you choose to complete.
- You can participate in an HRA and a Flexible Spending Account (FSA) at the same time. However, City of Tampa will determine the order under which claims may be reimbursed from the HRA or FSA.

Introduction - HRA

Who Is Eligible for the HRA And How To Enroll

You must be covered under a medical plan sponsored by City of Tampa and administered by UnitedHealthcare in order to participate in the HRA. You are enrolled in the HRA at the same time you enroll in your medical plan. You cannot elect it separately and you can't withdraw from it unless you also withdraw from the medical plan. Eligibility to participate in the Plan is described in this SPD, Section 2 - *Introduction*. Contact Human Resources if you have questions about eligibility and enrollment.

Each year during annual Open Enrollment, you have the opportunity to review and change your benefit election. You are permitted during annual Open Enrollment, or upon termination, to permanently opt out of coverage for the year and waive future reimbursements. Any changes you make during Open Enrollment will become effective as described in this SPD, Section 2 - *Introduction*.

Important
If you wish to change your benefit elections following a marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact Human Resources as described in this SPD, Section 2 - *Introduction* under the heading *Changing Your Coverage*. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

Cost of Coverage

You and City of Tampa share in the cost of the medical plan, there is no charge to you for participation in the financial account component of your Plan. Your contribution amount, (also known as a premium) depends on the medical plan you select and the family members you choose to enroll.

Your medical plan premium is deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld - and in most states, before state and local taxes are withheld. For more information on the Cost of Coverage please refer to Section 2 - *Introduction* under the heading *Cost of Coverage*.

Changing Your HRA Coverage

If you are hired during the Plan year or are enrolling in the Plan mid-year during a special enrollment period, coverage will become effective as described in Section 2 - *Introduction* under the heading *Changing Your Coverage*.

For detail on the employer contribution to your HRA for mid-year enrollment and/or status changes see this Section under the heading *How the HRA Works*, and look for "New Hires and Adjustments for Status Changes".

For information on ending your coverage please refer to this Section under the heading *When HRA Coverage Ends*.

How The HRA Works

How much money is allocated to your HRA – Employer Contributions

City of Tampa will allocate a specified amount of funds to your HRA on a plan year basis specific to the coverage category you enroll in. For each claim presented to the HRA, available funds will be used to pay for 100% of your HRA Eligible Expenses. The table below contains the details for the employer contribution to your HRA:

(Standard HRA)

Coverage Category	Annual Employer Contribution to your HRA[1]
■ Individual	$1,000
■ Spouse/ Domestic Partner	$1,000

[1]This is the only amount that will be placed in your HRA during the calendar year and may be used for HRA Eligible Expenses.

Please Note: The above amounts are not automatic. These amounts are dependent upon completion of certain activities as described in the *Health Incentives* Section below.

Health Incentives

UnitedHealthcare offers a health incentive and consumer engagement program that seeks to increase consumer awareness. Account credit incentives are provided when Employees and Spouses complete activities as described by the Employer:

- Personal health assessment (PHA);
- Certification of being tobacco free; and
- Online wellness webinars, onsite wellness classes or participation in a designated walking challenge.

Employees and Spouses register to complete the health assessment, certify tobacco use status and complete other incentive activities by visiting www.careatc.com.

Participation is completely voluntary and without extra charge. Qualifying activities and incentive amounts are fully described on the CareATC patient portal at www.careatc.com.

You are responsible for any tax consequences or liabilities incurred in connection with any incentive rewards received from your Employer.

Incented Contributions

The City of Tampa may contribute funds to your HRA after you have completed certain incentive activities.

New Hires And Adjustments For Status Changes

Mid-Year Enrollment

If you are hired during the Plan year or are enrolling in the Plan mid-year during a special enrollment period as a result of a change in status, the amount of the Employer contribution allocated to your HRA will be prorated on a monthly basis effective the first day of the month following the month in which you are enrolled in the Plan.

Status Changes

When you switch among coverage categories the City of Tampa's contribution amount allocated to your HRA may increase or decrease by category.

Under the Plan, if you increase your category (e.g. individual to family) the Employer contribution to your HRA is adjusted to your new category for that Plan year minus any amounts already accumulated or used in that Plan year. Any funds in your HRA that had rolled over from previous Plan years will remain with you.

If you decrease your category (e.g. you change from family to individual) the Employer contribution to your HRA is adjusted to your new category for that Plan year minus any amounts already accumulated or used in that Plan year. The amount in your HRA can not have a negative balance. Any funds in your HRA that had rolled over from previous Plan years will remain with you.

You can keep track of the funds in your HRA by going online to **www.myuhc.com**, by calling the toll-free number on your ID card or by checking your monthly member statement sent to you by UnitedHealthcare.

What Type of Medical Expenses Qualify for Reimbursement From The HRA

Not all health-related expenses qualify for reimbursement under the HRA Plan. Section 213(d) of the Internal Revenue Code of 1986, as amended from time to time defines what health care expenses are considered "qualified" medical expenses for federal income tax purposes. Only amounts that are paid specifically to reimburse eligible medical care expenses, as defined in Section 213(d), will be covered under the HRA Plan. Your Employer has determined which of those "qualified" medical expenses will be considered HRA Eligible Expenses under your Plan and reimbursable from your HRA.

Order of Accounts

If you choose to participate in multiple spending accounts be aware that a payment hierarchy does exist. The order in which your accounts must be used for reimbursements is described in the table below:

Account	Hierarchy Order of Accounts
■ Health Reimbursement Account (HRA)	First
■ Flexible Spending Account (FSA)[1,2]	Second

[1]While the HRA and FSA may cover some of the same types of expenses, the FSA may be funded with pre-tax contributions under a salary reduction arrangement.

[2]Expenses reimbursed through the HRA cannot also be reimbursed through the FSA.

What Happens To Remaining Balances In Your HRA

If you don't spend all the funds in your HRA during the initial plan year, and you re-enroll in the Plan for the following year you forfeit any unused funds remaining in the account.

If you don't re-enroll in the Plan for the following year, you forfeit any unused funds remaining in the account.

Health Care Spending Card Debit Mastercard®

The Health Care Spending Card Debit MasterCard® is a payment mechanism that allows members a means for direct payment of HRA Eligible Expenses, per your specific plan design, to UnitedHealthcare network providers. Payment for HRA Eligible Expenses will come directly from your HRA and eliminates the need for you to submit most paper claims.

You will be provided with two Health Care Spending Card Debit MasterCard®s, with terms and conditions and activation information that may be used at certain locations where MasterCard® is accepted. Contact the customer service number listed on the Health Care Spending Card Debit MasterCard® with questions or to request additional cards.

Use of the Health Care Spending Card Debit MasterCard® is voluntary. The card must be activated prior to use. To activate the Health Care Spending Card Debit MasterCard® you will need to call the toll-free number indicated on the sticker affixed to the card and follow the voice prompts to activate. When you activate the Health Care Spending Card Debit MasterCard®:

- Prior to the plan effective date, wait one (1) business day after the plan effective date before you utilize your card;
- After the plan effective date, the card will be ready to use one (1) business day following activation.

If you decide not to activate the Health Care Spending Card Debit MasterCard®, simply destroy and discard both cards. However, you can be reimbursed for HRA Eligible Expenses by completing a paper reimbursement form available from Anadarko Petroleum Corporation or found on www.myuhc.com and as described under Section, *Requesting a Reimbursement from Your HRA* or for HRA Eligible Expenses by using the automatic reimbursement (auto-submission) feature described under the Section, *Claims Submission*.

The Internal Revenue Service may require that you provide a receipt, statement or Explanation of Benefits for certain HRA Eligible Expenses that have already been reimbursed through your card in order to prove that the services received were for qualified medical expenses incurred within the plan year, as defined by your Anadarko Petroleum Corporation in the medical plan SPD. You will be notified through a letter if you need to provide such information. If UnitedHealthcare does not receive the required documents as described in the letter, your card will be inactivated in accordance with applicable IRS regulations and guidelines. If UnitedHealthcare determines that the claim was not for a qualified medical expense as described in the letter this will be considered an overpayment to you and UnitedHealthcare will automatically withhold the payment of future claims until the full amount of the overpayment is received. If your card is inactivated due to the payment of

an ineligible expense or the lack of documentation as described in your letter we will activate your card upon receiving the requested documentation or the payment in full of any outstanding overpayment(s).

UnitedHealthcare Network Providers

The consumer website, www.myuhc.com, contains a directory of medical, dental and vision providers in UnitedHealthcare's provider network. While network status may change from time to time, www.myuhc.com has the most current source of provider network information. Use myuhc.com to search for network providers available in your specific plan design.

Using the Health Care Spending Card Debit MasterCard®

In order to use the Health Care Spending Card Debit MasterCard®, you will need to enter 'credit' on the POS bankcard terminal just as if you were purchasing an item using a credit card. Each time the card is used for payment, you will sign a receipt. Your FSA and card are regulated by the IRS, therefore you should retain all itemized receipts generated from the Health Care Spending Card Debit MasterCard® because certain payments must be verified and UnitedHealthcare may request this receipt from you to ensure that payment was made for an HRA Eligible Expense. Credit card receipts that do not itemize expenses are not sufficient to verify payment. Amounts paid that cannot be verified may be considered taxable income to you.

Once you swipe the Health Care Spending Card Debit MasterCard® through the POS bankcard terminal, your available benefit balance is verified. The card validates your purchases real-time and automatically debits your HRA account based on the guidelines established by the IRS and your specific plan design. A claim number is assigned to the transaction.

Qualified Locations and Providers

The Health Care Spending Card Debit MasterCard® may not be used at point of sale to make a purchase from non-participating merchants. You will need to pay using another form of payment, and then submit eligible expense receipts for reimbursement as described under the Section, *Requesting Reimbursement from your HRA*.

The Health Care Spending Card Debit MasterCard® may be used for a point of sale purchase at any UnitedHealthcare network provider or participating merchant with a Point-of-Service (POS) bankcard terminal that accepts MasterCard® such as a network hospital, network physician and retail network pharmacy counters.

No Personal Identification Number ("PIN") is required when you use the Health Care Spending Card Debit MasterCard®. At the point of sale choose 'credit' on the POS bankcard terminal just as if you were purchasing an item using a credit card. Each time the card is used for payment, you will sign a receipt. Your HRA and card are regulated by the Internal Revenue Service; therefore you should retain all itemized receipts generated from the Health Care Spending Card Debit MasterCard®. Certain payments must be verified and UnitedHealthcare may request this receipt from you to ensure that payment was made for a

qualified HRA expense. Credit card receipts that do not itemize expenses are not sufficient to verify payment. Amounts paid that cannot be verified may be considered taxable income to you.

Once you swipe the Health Care Spending Card Debit MasterCard® through the POS bankcard terminal, your available benefit balance is verified. The card validates your purchases in real-time and automatically debits your HRA account based on the guidelines established by the IRS and your specific plan design as described under Section, Your HRA. A claim number is assigned to the transaction.

Partial Payment Authorization

Partial authorization capability allows you to use your Health Care Spending Card Debit MasterCard® with transactions amounts greater than the funds available in your HRA for a portion of the transaction at merchants that accept partial authorization. For example, if you purchase an item that costs $20 and you only have $10 remaining in your HRA, the HRA balance of $10 will be authorized towards the purchase and you are responsible for paying the remaining balance of $10 with another form of payment. Note: not all merchants accept partial authorization.

Member Health Statements and HRA Yearly Statements

Member Health Statements are available on the consumer website, myuhc.com. A member health statement is produced whenever there is claims activity for a member. You will receive monthly health statements and a HRA yearly statement which will include your card activity. If you note a discrepancy with a card transaction, call the number on your Health Care Spending Card Debit MasterCard® to resolve the issue.

HRA Claim Procedures

Claims Submission

City of Tampa has designed your HRA to allow certain claims to be automatically submitted to your account for reimbursement. UnitedHealthcare will coordinate payments from your HRA for medical claims and other 213d expenses. When you have both an HRA and an FSA, the feature will disable for both spending accounts.

There are some types of claims that will not be processed automatically for which you will need to submit a claim manually; for additional information on these claims see the header below called *When to Submit a Claim*.

When auto-submission is elected all reimbursements from the HRA will be sent directly to the provider, exceptions are listed below. When no provider information is available the reimbursement will be sent to you. In the 3 exception situations listed below, the reimbursement from the HRA will go directly to you and not the provider:

- Manually submitted claims (paper claims you submit directly).
- Non-Network provider claims.
- Claims adjustments.

Note
The Plan's Access Point must be first met before reimbursement will be made from the HRA.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will process the payment for the medical plans portion of the cost of the Covered Health Services and send it directly to the Physician or facility.

Funds allocated to your HRA will be available to help you pay a portion of your out-of-pocket costs under the medical plan as described in this SPD in Section 3 - *How the Plan Works*. UnitedHealthcare will process the payment for a portion of your cost of the Covered Health Services from available funds in your HRA or FSA and send it directly to the Physician or facility automatically. This feature can be turned on and off by accessing myuhc.com. There are some types of claims that will not be paid directly to the provider, they are as follows: manually submitted claims and adjustments and out of network provider claims. These types of claims will always pay you directly.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on your ID card.

If you receive Covered Health Services from a non-Network provider funds from your HRA or FSA will automatically be reimbursed to you, up to the amount available in your HRA or FSA after having met your HRA Access Point. You will only be reimbursed from your HRA or FSA for expenses incurred while you are a Covered Person under the Plan.

When to Submit a Claim

There are some types of claims that will not be processed automatically for which you will need to submit a claim. When Auto-rollover feature does not apply, you must submit a claim for reimbursement from your HRA or FSA including any other types of expenses other than Covered Health Services and any health expenses not submitted to UnitedHealthcare.

If you receive a bill for Covered Health Services from a provider, you must send the bill to UnitedHealthcare for processing.

Important - Timely Filing of Non-Network Claims
All claim forms must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by City of Tampa. This 12-month requirement does not apply if you are legally incapacitated.

How to File Your Claim for Reimbursement from the HRA

To be reimbursed from your HRA simply submit a reimbursement form, called a Request for Withdrawal Form, for the HRA Eligible Expenses that have been incurred. A Request for Withdrawal Form is available from City of Tampa or on the Internet at

www.myuhc.com. For reimbursement from your HRA, you must include proof of the expenses incurred as indicated on the Request for Withdrawal Form. For HRA Eligible Expenses, proof can include a bill, invoice, or an Explanation of Benefits (EOB) from your group medical plan under which you are covered. An EOB will be required if the expenses are for services usually covered under group medical plans, for example, charges by surgeons, doctors and hospitals. In such cases, an EOB will verify what your out-of-pocket expenses were after payments under other group medical plans.

To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare HRA Claims submittal address:

Health Care Account Service Center
PO Box 981506
El Paso, TX 79998-1506

Important
You can view EOB's and Health Statements online via **myuhc.com**.
Myuhc.com includes many features such as the option to:
- View your HRA summary page detailing contributions and amount left in your HRA;
- View your HRA Claims Summary including claim transaction details.

Health Statements

Each month that UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at myuhc.com. See Section 13, *Glossary* for the definition of Explanation of Benefits.

Requesting Reimbursement from Your HRA

If you have allocated funds available in your HRA you may submit a claim for reimbursement for the HRA Eligible Expenses from your HRA. If you submit a request for

reimbursement for Network claims, the request must be received no later than 90 days following the end of the plan year in which you are eligible under this Plan. All claim forms for non-Network claims must be submitted within 365 days of the date of service. If you don't provide this information to the Claims Administrator within this timeframe, your claim will not be eligible for reimbursement, even if there are funds available in your HRA. This time limit does not apply if you are legally incapacitated.

You cannot be reimbursed for any expense paid under your medical plan, and any expenses for which you are reimbursed from your HRA cannot be included as a deduction or credit on your federal income tax return.

Important Note

- The date on which you incurred an eligible medical expense is used when deducting amounts from your HRA. This allows your HRA to act like a savings account, available for your use when your claim is paid.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number provided by City of Tampa before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied claim, you or your authorized representative must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

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

If you wish to request a formal appeal of a denied claim for reimbursement, you should call the number provided by City of Tampa to obtain the UnitedHealthcare address where the appeal should be sent. For Urgent Care claims that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Appeals for your HRA should be submitted to:

UnitedHealthcare – HRA Group Claims
P.O. Box 981178
El Paso, TX 79998-1178

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

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

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from City of Tampa within 60 days from receipt of the first level appeal. City of Tampa must notify you of the benefit determination within 30 days after receiving the completed appeal.

Note: Upon written request and free of charge, any covered persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. City of Tampa will review all claims in accordance with the rules established by the U.S. Department of Labor. City of Tampa's decision will be final.

For additional information on claims procedures and appeals, including the time frames which you and UnitedHealthcare are required to follow, please refer to Section 8, *Claims Procedures*.

HRA Coordination of Benefits (COB) And Subrogation And Reimbursement

For information on how your Benefits under this Plan coordinate with other medical plans and how coverage is affected if you become eligible for Medicare, refer to Section 10 - *Coordination of Benefits*.

Overpayment and Underpayment of Benefits

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan. For further information on COB refer to Section 10 - *Coordination of Benefits*.

Subrogation and Reimbursement

The Plan has a right to subrogation and reimbursement, as defined in Section 11 - *Subrogation and Reimbursement*.

When HRA Coverage Ends

Your coverage under the Plan ends as described in Section 12 - *When Coverage Ends*.

Continuation of Coverage - Consolidated Omnibus Budget Reconciliation Act ("COBRA")

The requirements of the Consolidated Omnibus Budget Reconciliation Act ("COBRA") may apply to the Health Reimbursement Account. You should call City of Tampa to find out whether this Plan is subject to COBRA. If the Plan is subject to COBRA see "Optional Continuation Coverage under your Health Care Spending Account (COBRA)".

COBRA continuation coverage must be offered with respect to a participant's HRA when the Plan is subject to COBRA. If your employment terminates for any reason the funds in your HRA will revert back to us after your claim run-out period, unless you elect COBRA coverage as described in Section 11 - *When Coverage Ends* under the heading *Changing You Coverage*. If you elect COBRA coverage, HRA funds will remain available to assist you in paying your out-of-pocket costs under the medical plan while COBRA coverage is in effect. The HRA balances under COBRA are recalculated using the methods elected by City of Tampa for mid-year enrollment and/or status changes; as described in this Section under the heading *How the HRA Works*, and look for *New Hires and Adjustments for Status Changes*.

HRA Glossary

Many of the terms used throughout this Section may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how benefits are paid. The HRA Glossary defines terms used throughout this Section, but it does not describe the benefits provided by the Plan. Capitalized terms not otherwise defined in this section have the meaning set forth in your medical plan SPD.

HRA - Health Reimbursement Account or HRA. It is an IRS Section 105 and 106 account that follows standard regulations and tax benefits for such accounts. It can only be used for qualified medical expenses.

HRA Access Point - the initial amount you must pay each plan year for Covered Health Services before you receive your HRA Benefit Dollars in your HRA. The Plan will begin paying Benefits once you have satisfied the HRA Access Point. You must still satisfy the Annual Deductible. The HRA Access Point is shown in the first table in Section 4, *How the HRA Plan Works*, under the heading *How much money is allocated to your HRA - Employer Contributions*. The HRA Access Point applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 14, *Prescription Drugs*.

HRA Eligible Expense - an expense that you incur specific to health care on or after the date you are enrolled in the HRA Plan and include the following: (i) an eligible medical expense as defined in Section 213(d); (ii) an Eligible Expense as defined in your medical plan SPD; (iii) a medical expense not paid for under your active medical Plan as it represents your portion of responsibility for the cost of health care such as Coinsurance; and (iv) a medical expense not reimbursable through any other plan covering health benefits, other insurance, or any other accident or health plan.

HRA Plan - The Health Reimbursement Account portion of the City of Tampa Welfare Benefit Plan.

HRA Administrative Information

This Section includes information on the administration of the HRA portion of the Plan as well as information required of all Summary Plan Descriptions. Information on the medical portion of the Plan can be found in this SPD, Section 17, Important Administrative Information.

Claims Administrator - HRA

UnitedHealthcare is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the Company. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

United Healthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

Type of Administration

The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by United HealthCare Insurance Company. The named fiduciary of Plan is City of Tampa, the Plan Sponsor.

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

SECTION 17 - IMPORTANT ADMINISTRATIVE INFORMATION

What this section includes:
- Plan administrative information.

This section includes information on the administration of the medical Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Additional Plan Description

Claims Administrator: The company which provides certain administrative services for the Plan Benefits described in this Summary Plan Description.

United HealthCare Services, Inc.
185 Asylum St.
Hartford, CT 06103-3408

The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by United HealthCare Insurance Company. The named fiduciary of Plan is City of Tampa, the Plan Sponsor.

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

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

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

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

ATTACHMENT II - 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

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

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

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

ATTACHMENT III – NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to United HealthCare Services, Inc., on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. UnitedHealthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: Qualified interpreters
- Information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

Claims Administrator Civil Rights Coordinator
United HealthCare Services, Inc. Civil Rights Coordinator UnitedHealthcare Civil Rights Grievance P.O. Box 30608 Salt Lake City, UT 84130 The toll-free member phone number listed on your health plan ID card, TTY 711 UHC_Civil_Rights@UHC.com

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

ATTACHMENT IV – GETTING HELP IN OTHER LANGUAGES OR FORMATS

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Language	Translated Taglines
1. Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
2. Amharic	**ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711**
3. Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
4. Armenian	Թարգմանիչ պահանջէլու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամնէրի հէռախոսահամարով, սեղմե՛ք 0: TTY 711
5. Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
6. Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711
7. Bengali-Bangala	অনুবাদকরে অনুরে াধ থাকলে, আপনার স্বাস্থ্য পরকিল্পনার আই ডি কার্ড এ তালকিাভুক্ত ও কর দতিে হবে না এমন টলেফিে ান নম্বরে ফে ান করুন। (০) শূণ্য চাপুন। TTY 711
8. Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711

Language	Translated Taglines
9. Cambodian-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតចគ្រេថ្លៃសំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
10. Cherokee	Θ D4Ꭴ ᏏᎵ ᏗCZᎮᏗ Ꮧ4ᏫᎫᏗ ᏥAᏯᎳW ᎥᏓ GᏙᎵ VᏋ ᏏR ᏗJAVᏗ ACᏫᎫVᏗ ᎢΘᏂᏫᎫᏗT, ᎤᏤ0ᏬᎫᏓ 0. TTY 711
11. Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
12. Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
13. Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
14. Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711
15. French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
16. French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
17. German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
18. Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711

Language	Translated Taglines
19. Gujarati	તમને વનિા મૂલ્યે મદદ અને તમારી ભાષામાં માહતિી મેળવવાનો અધકિાર છે. દુભાષયિા માટે વનિતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, 0 દબાવો. TTY 711
20. Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo ponoʻī me ka uku ʻole ʻana. E kamaʻilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
21. Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नःशुल्क प्राप्त करने का अधकिार है। दुभाषएि के लएि अनुरोध करने के लएि, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
22. Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.
23. Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwughị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
24. Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salun-at, ipindut ti 0. TTY 711
25. Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
26. Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711

Language	Translated Taglines
27. Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は 711です。
28. Karen	နအိဉ်ဒီးတါ်ခွဲးတါ်ယာ်လၢနကဒိးနှုါ်ဘဉ်တါ်မၤစၢၤဒီးတါ်ဂ့ါ်တါ်ကျိုလၢနကျိာ်ဒဉ်နဝဲလၢတလိဉ်ဟှဉ်အ ပှုၤဘဉ်နှုဉ်လီၤ.လၢတါ်ကယှနှုါ်ပှၤကတိၤကျိုးထံတါ်တဂၤအဂီါ်ကိးဘဉ်လီတဲစိအကျိုလၢကရၢဖိအတလိဉ်ဟှဉ်အပှုၤလၢအအိဉ်လၢနတါ်အိဉ်ဆူဉ်အိဉ်ချအတါ်ရဲဉ်တါ်ကျဲၤ အကးအလိၤဒီးဆီဉ်လီၤနီါ်ဂ်ါ် 0 တကှါ်.TTY 711
29. Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
30. Kru- Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711
31. Kurdish-Sorani	مافەی ئەوەت هەیە کە بێبەرامبەر، یارمەتی و زانیاری پێویست بە زمانی خۆت وەرگریت. بۆ داواکردنی وەرگێڕێکی زارەکی، پەیوەندی بکە بە ژمارە تەلەفۆنی نووسراو لەناو ئای دی کارتی پیناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە .TTY 711
32. Laotian	ທາ່ນມສິດິທຈື່ະໄດຮັບັການຊວ່ຍເຫອຼືແລະຂມ້ນູຂາ່ວສານທເປີນັພາສ າຂອງທາ່ນບມ່ຄິາ່ໃຊຈ້າ່ຍ. ເພອື່ຂຮໍ້ອ້ງນາຍພາສາ,ໂທຟຣຫີາຫມາຍເລກໂທລະສບັສາໍລບັສະມາ ຊກິທໂຶດລ້ະບໄຸວໃ້ນບດັສະມາຊກິຂອງທາ່ນ,ກດົເລກ 0. TTY 711
33. Marathi	आपल्याला आपल्या भाषेत वनिामूल्य मदत आणि माहतिी मळिण्याचा अधकिार आहे. दूभाषकास वनिंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास वनिामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
34. Marshallese	Eor aṃ maroñ ñan bok jipañ im meḷeḷe ilo kajin eo aṃ ilo ejjeḷọk wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūrḷok nōṃba eo eṃōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711
35. Micronesian-	Komw ahneki manaman unsek komwi en alehdi sawas oh

Language	Translated Taglines
Pohnpeian	mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.
36. Navajo	T'áá jíík'eh doo bą́ą́h 'alínígóó bee baa hane'ígíí t'áá ni nizaád bee niká'e'eyeego bee ná'ahoot'i'. 'Ata' halne'í ła yíníkeedgo, ninaaltsoos nitł‘izí ‘ats’íís bee baa’ahayá bee nééhozinígíí bikáá’ béésh bee hane’í t’áá jíík’eh bee hane’í biká’ígíí bich’į’ hodíilnih dóó 0 bił 'adidíílchił. TTY 711
37. Nepali	तपाईले आफ्नो भाषामा नःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधकिार तपाईसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईको स्वास्थ्य योजना परचिय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थचि्नुहोस्। TTY 711
38. Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wɛ̈rëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.
39. Norwegian	**Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711**
40. Pennsylvania Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. **TTY 711**
41. Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
42. Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਚਿ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਕਿਾਰ ਹੈ| ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦੱਤਿੇ ਗਏ ਟਾੱਲ ਫ੍ਰੀ ਮੈਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ|
43. Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
44. Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711

Language	Translated Taglines
45. Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
46. Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711
47. Samoan- Fa'asamoa	E iai lou āiā tatau e maua atu ai se fesoasoani ma faʹamatalaga i lau gagana e aunoa ma se totogi. Ina ia faʹatalosagaina se tagata faʹaliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
48. Serbo-Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
49. Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
50. Sudanic- Fulfulde	Ɗum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo"u 0. TTY 711.
51. Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
52. Syriac-Assyrian	ܐܢܬܘܢ ܐܝܬܠܘܟܘܢ ܫܘܩܬܐ ܕܩܒܠܬܘܢ ܗܝܪܬܐ ܘܡܕܥܢܘܬܐ ܒܠܫܢܐ ܕܝܘܟܘܢ ܟܠܝܫ ܥܡ ܢܘܡܪܐ ܕܡܬܘܪܓܡܢܐ ܩܐ ܒܥܝܬܐ ܕܩܪܘܢ ܐܢܝ ܡܢܐ ܕܡܚܒܘܫܝܐ ܥܠ ܟܪܛܝܣܐ ܕܐܝܠܗ ܕܝܘܟܘܢ ܡܚܨܝܐ ܐܢܝ 0. TTY 711
53. Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711

Language	Translated Taglines
54. Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంటు మరియు సమాచార పొందడ ానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నెంబరుకు ఫోన్ చేసి, 0 పరెన్ చేసుకో. TTY 711
55. Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
56. Tongan-Fakatonga	‘Oku ke ma’u ‘a e totonu ke ma’u ’a e tokoni mo e ‘u fakamatala ‘i ho’o lea fakafonua ta’etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta’etotongi ma’ae kau memipa ‘a ee ‘oku lisi ‘I ho’o kaati ID ki ho’o palani ki he mo’uilelei, Lomi’I ‘a e 0. TTY 711
57. Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki "0". Ren TTY, kori 711.
58. Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0’a basınız. TTY (yazılı iletişim) için 711
59. Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
60. Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
61. Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
62. Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דרוקט 0. TTY 711

Language	Translated Taglines
63. Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá ògbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ '0'. TTY 711