2024 Retiree Health Care Program Summary Plan Description

Table of contents

Introduction

About this document

This is the summary plan description (SPD) for the U.S. Bank Retiree Health Care Program ("Program"), a component of the U.S. Bank Comprehensive Welfare Benefits Plan. Read the information carefully and file it with your benefits materials.

U.S. Bank has established the U.S. Bank Comprehensive Welfare Benefits Plan, which provides certain welfare benefits to eligible U.S. Bank employees. For convenience, U.S. Bank has created a separate summary for each welfare benefit program offered under the Plan. This SPD is effective Jan. 1, 2024 and applies only to retirees enrolled in the Early Retiree Medical and UnitedHealthcare Group Medicare Advantage (PPO) plan options under the Retiree Health Care Program. For a list of the separate SPDs describing the other categories of benefits available to U.S. Bank employees under the U.S. Bank Comprehensive Welfare Benefits Plan, please visit **Your Total Rewards**.

The information in this SPD pertains in full to the Early Retiree Medical UHC CPN plan option.

This document is intended only to provide a summary of the benefits that are available under the Retiree Health Care Program. The final administration of claims is handled by the claims

administrator. If there is any discrepancy between this document and the official plan/program documents (for benefits where the summary plan description is not part of the plan document), the official plan/program documents govern. This document does not create any vested right to any benefit under the Retiree Health Care Program.

UnitedHealthcare Group Medicare Advantage (PPO) plan with Prescription Drugs

If you are enrolled in the UnitedHealthcare Medicare Advantage (PPO) plan with Prescription Drugs, you will receive materials directly from the UnitedHealthcare Group Medicare Advantage (PPO) plan explaining the benefits provided and any requirements or limitations for receiving benefits. When read with the information in the following sections of this SPD, these materials are the complete summary plan description for the UnitedHealthcare Group Medicare Advantage (PPO) plan.

- Introduction
- Your program options and claims administrators
- Cost of retiree health care coverage
- Who's eligible
- Enrolling
- Situations that could affect your coverage (including becoming Medicare-eligible)
- Coverage cancellation
- When coverage ends
- Continuing coverage under COBRA
- Required legal information
- Whom to contact

The materials you receive from the UnitedHealthcare Group Medicare Advantage (PPO) plan will include important information regarding the doctors you may see, the medical services you may receive, any copayments or other out-of-pocket expenses for which you may be responsible, requirements you must satisfy before receiving services (e.g., preadmission notification and prior authorization) and the services and expenses that are excluded under the benefit plan.

Your responsibilities

- Carefully review this information and keep it for future reference.
- Enroll or request qualifying changes by the deadlines described in this document. If you miss certain deadlines, processing may be delayed or your request may not be processed at all.
- After enrolling or making a change, carefully review your confirmation statement and any other documents.
- Provide documentation as requested to verify eligibility of any dependents you enroll.
- Verify that the provider you or a covered family member uses is a network pharmacy or network provider before you receive care to ensure eligible services are covered at the highest benefit level.
- Call U.S. Bank Employee Services if you have questions not answered by the information in this document, or contact your claims administrator/insurance company for specific questions about coverage or claims information.

Eligibility and enrollment

The U.S. Bank Retiree Health Care Program is closed to new enrollments for employees that terminated/retired on or after Jan. 1, 2014. You are eligible for the Retiree Health Care Program if you were enrolled on or before this date. Newly eligible dependents can be added to coverage if enrolled within 60 days of becoming an eligible dependent, see "Who's eligible," "Enrolling" and "Situations that could affect your coverage."

Your program options and claims administrators

The health care option available to you is determined by your age (as the U.S. Bank retiree) and Medicare eligibility. For any of the options available to you, there are two coverage levels:

- You Only (the retiree only); or
- Family (you/retiree; and any eligible dependents).

You (the retiree) are younger than 65 and not Medicare-eligible (regardless of any dependent's age or Medicare eligibility)

Options	Claims administrators
You and your dependents will be enrolled in **Early Retiree Medical Choice Plus (CPN)**	**Medical:** UnitedHealthcare Services, Inc. **Pharmacy:** Optum Rx

You (the retiree) and your dependent(s) are 65 or older, or you (the retiree) are younger than 65 and Medicare-eligible

Options	Claims administrators
You and your dependents will be enrolled in **UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs**	**Medical:** UnitedHealthcare® Group Medicare Advantage (PPO) **Pharmacy:** UnitedHealthcare Medicare Part D prescription drug plan administered by Optum Rx

You (the retiree) are 65 or older or younger than 65 and Medicare-eligible, and your dependent(s) are younger than 65 and not Medicare-eligible

Options	Claims administrators
You will be enrolled in **UnitedHealthcare Group Medicare Advantage (PPO)**	**Medical:** UnitedHealthcare® Group Medicare Advantage PPO **Pharmacy:** UnitedHealthcare Medicare Part D prescription drug plan administered by Optum Rx
Your dependent(s) will be enrolled in **Early Retiree Medical Choice Plus (CPN)**	**Medical:** UnitedHealthcare Services, Inc. **Pharmacy:** Optum Rx

When you or your dependent(s) turn age 65 or become Medicare-eligible before age 65 you must enroll in Medicare Part A and Part B

If your covered dependent(s) become Medicare-eligible and are enrolled in one of the pre-65 health care options, the Program expects your covered dependents will enroll in Medicare Parts A and B as soon as they are eligible to do so. Medicare Parts A and B will be considered the primary insurer, regardless of whether your covered dependent(s) is actually enrolled in Medicare or not and the Program will provide secondary coverage. This means that if your covered dependent(s) do not enroll in Medicare parts A and B when first eligible, you will be responsible for paying the portion Medicare

would have paid had your dependent(s) been enrolled in Medicare when first eligible, in addition to any liability you may be responsible for under your coverage in the Program.

UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs

The UnitedHealthcare Group Medicare Advantage (PPO) plan is available to retirees enrolled in Medicare Parts A and B and their Medicare-eligible dependents (as long as the retiree is also enrolled in this option). This option delivers all of the benefits of Medicare Parts A and B, plus additional benefits. (You must be enrolled in Medicare Parts A and B to remain enrolled in the Program. If you are not enrolled in Medicare Parts A and B, your coverage in the Program will be cancelled.)

Under this option, you will generally receive benefits only for covered services you receive from providers that accept the terms of your UnitedHealthcare Group Medicare Advantage (PPO) plan option.

The UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs is offered through an insurance contract with the UnitedHealthcare Group Medicare Advantage (PPO) plan who has the sole authority, discretion and responsibility to interpret and construe the plan and, determine all factual and legal questions under such plan, including but not limited to eligibility, the entitlement of benefits and the amounts of benefits to be paid, and determine all questions arising in the administration of the plan. The UnitedHealthcare Group Medicare Advantage (PPO) plan provides their own materials. If you enroll in the Program, carefully review and refer to these materials. If you have questions about your health care option, Medicare Part D coverage or claims information, contact the UnitedHealthcare Group Medicare Advantage (PPO) plan.

Note: If you enroll in an individual Part D prescription drug plan or another Medicare Advantage plan, you will be disenrolled from your U.S. Bank plan. Once your U.S. Bank coverage is cancelled, you will not be allowed to re-enroll in the plan.

Early Retiree Medical option claims administrators

United HealthCare Services, Inc. (UnitedHealthcare) is the claims administrator for medical services. Optum Rx is the claims administrator for prescription drug coverage.

Networks

Advantages of using network providers

When you receive services, you are encouraged to use network providers or network pharmacies for the following reasons:

- **Higher level of coverage** – You and your covered dependents (including dependents not living with you or attending school away from home) will receive a higher level of coverage for covered services and prescriptions when using network providers or network pharmacies. If you or your covered dependents use a non-network provider or non-network pharmacy, you will receive a lower level of coverage. See "What's covered – medical" and "What's covered – pharmacy" to learn more.
- **Filing claims** – When you use network providers or network pharmacies, your claims will be filed for you. When you use non-network providers or non-network pharmacies, you may need to file your own claims. See "How benefits are paid" for more information on medical and pharmacy claims.

- **Eligible expenses** – By using network providers, you generally will only pay eligible expenses negotiated by UnitedHealthcare to ensure the fees charged by providers are not excessive. If you obtain care from a non-network provider, you may have to pay the amount that exceeds eligible expenses. The amount in excess of eligible expenses could be significant and it may not count toward your deductible or out-of-pocket maximum. See "Eligible expenses" for more information and "Advocacy services" for information on the assistance available to you.

See the "Glossary" for definitions of network and non-network providers, network and non-network pharmacies.

Determine your network

Your network is based on the service being received; see the table below:

Service	Your network
Medical services	**UnitedHealthcare Choice Plus Network (CPN)** Additional provisions apply for infertility services (including prescription drugs), obesity surgery and transplants. See "Designated providers." In limited circumstances, there may be a location without adequate network access. See "If a network provider is not available" for additional information.
Prescriptions	**UnitedHealthcare/Optum Rx** Most pharmacies and pharmacy chains in the United States are in the Optum Rx retail pharmacy network. For prescriptions by mail, you need to use Optum home delivery or the Optum specialty pharmacy.

Find a network provider

To find a network provider or network pharmacy, call UnitedHealthcare/Optum Rx or visit their site. Every effort is made to ensure the list of providers on the website is up-to-date and accurate. However, networks are subject to change throughout the year. It is your responsibility to verify a provider's network or participation status with your claims administrator before you or your covered dependents receive care.

Additional considerations for finding a medical provider

Designated providers

UnitedHealthcare has clinical programs that provide access to designated providers who specialize in certain types of care to provide the best possible care. You are required to use UnitedHealthcare's clinical programs prior to receiving services for infertility services (including prescription drugs), obesity surgery and transplants. Infertility services (including prescription drugs), obesity surgery, and transplants are not covered if you do not use UnitedHealthcare's clinical programs. You are encouraged but not required to use UnitedHealthcare's clinical programs for cancer, congenital heart disease and neonatal services. Exceptions and additional provisions apply; see "Cancer services," "Congenital heart disease services," "Infertility services," "Neonatal services," "Obesity surgery" and "Transplantation services" for more information.

UnitedHealth Premium® Program
This program identifies UnitedHealthcare network physicians that meet standards for quality and cost efficiency. UnitedHealthcare uses evidence-based medicine and national industry guidelines to evaluate quality. The cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care. For details on the program including how to locate a UnitedHealth Premium Physician, call UnitedHealthcare or visit their site. You are not required to use providers in this program to receive network benefits.

If a network provider is not available

If you're unable to locate a network provider call UnitedHealthcare. When necessary, UnitedHealthcare will approve a network gap exception, allowing you to receive the network level of benefits for services received from a non-network provider. Approval for the network gap exception must be granted by UnitedHealthcare before you receive care.

There are two types of network gap exceptions that can be approved as follows:

- Geographic exceptions when there is no network provider in the required specialty available within a 30-mile radius of your home zip code; or
- Clinical exceptions when there is a specialist within the specified mile radius; however, the specialist cannot accommodate your diagnosis or condition. 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. For example, the network provider's specialty is dermatology, but the dermatologist does not treat Lyme disease.

To initiate a network gap exception, call UnitedHealthcare. Make sure you have the necessary procedure and diagnosis codes from your provider that he/she will be billing before calling UnitedHealthcare.

UnitedHealthcare will review your request within 15 business days and notify you of their decision. If approved, network gap exceptions are valid for a three-month period. Contact customer service at the number on your ID card for further assistance regarding these requests.

Transition of care

If you are planning to enroll a newly eligible dependent in the to the Early Retiree Medical option and they are currently being treated by a provider who is not in the network applicable to your location, and treatment is expected to continue after you enroll, your covered family member may qualify for transition of care (TOC). TOC allows you to be treated by your current non-network provider for a specified period (determined by the individual situation) and receive the network level of benefits.

TOC is only available for the treatment of acute conditions and not for the convenience of the member being treated. Examples of acute conditions are end-stage renal disease and dialysis, non-surgical cancer therapies (including chemotherapy and radiation), transplants (solid organ and bone marrow), and conditions where transition of care is required by federal law. If you or a covered family member is pregnant and expects to be in the second or third trimester as of the effective date of

coverage, you/she will automatically be eligible for TOC through the first postpartum visit. However, you or your family member must still complete a form to request TOC.

To request TOC for medical services, you and your physician will need to complete the form on UnitedHealthcare's site. To request TOC for Optum Behavioral Solutions, call UnitedHealthcare at the number on your ID card. In both instances, you may also need to submit supporting medical information related to your request. Upon receipt of the information, either UnitedHealthcare or Optum Behavioral Solutions will review your request and notify you of approval or denial. If approved, the notification will indicate the duration of the TOC. During this time, you are responsible for notifying UnitedHealthcare or Optum Behavioral Solutions prior to receiving certain services or being admitted to the hospital (see "Coverage requirements, limitations and exclusions – medical") and you may need to file your own claims (see "How benefits are paid").

For additional information on TOC, call UnitedHealthcare.

Identification cards

After you enroll, you will receive an ID card mailed to your home address from UnitedHealthcare to be used for your medical and pharmacy services. You must present the ID card when receiving care, so your claim will be handled properly and promptly. If you do not, you may need to pay for services yourself and file a claim for reimbursement. You may request additional or replacement ID cards by contacting UnitedHealthcare.

Cost of retiree health care coverage

The cost of retiree health care coverage for participants in the Program is based on claims experience and medical expense projections. The cost is generally adjusted on an annual basis and changes on Jan. 1. The cost could, however, at the discretion of U.S. Bank, be changed more frequently.

Retiree health care credits

Employees that met age and service requirements were able to accumulate retiree health care credits from Jan. 1, 2002, through Dec. 31, 2013. Effective Jan. 1, 2014, employees can no longer accumulate retiree health care credits. Eligible employees who retired before Jan. 1, 2014, may use their retiree health care credits as described below. Employees who did not retire before Jan. 1, 2014, forfeited any accumulated retiree health care credits.

Nature of credits and reservation of rights to change credits

As long as U.S. Bank keeps the credits structure in place in its Retiree Health Care Program, it will, for bookkeeping purposes, keep a record of any credits you accumulated. Your accumulated credits will be used to offset your cost of Retiree Health Care Program coverage for you and any covered dependents. Accumulated credits are not like accounts in a 401(k) or pension plan; no trust holds these credits, and there is no bank account in which the credits are deposited.

If you did not retire by Dec. 31, 2013, or you were not eligible to enroll in retiree health care on/or before Dec. 31, 2013, your credits and deemed interest were forfeited under all circumstances. Credits cannot be paid out to you or used for any other purpose than payment toward U.S. Bank retiree health care coverage under the Program.

Additionally, U.S. Bank is not obligated to continue either the Program or the application of retiree health care credits toward the cost of the coverage. U.S. Bank could terminate your coverage altogether or could amend the Program to eliminate or change (including reducing) the credits – including any credits you have already accumulated. This is because retiree health care coverage is not a 'vested' benefit and U.S. Bank has retained its full authority and discretion to amend or terminate the Program.

Interest on retiree health care credits

Credits are deemed to receive interest payments of 5.5% annually. If you have accumulated retiree health care credits, your remaining credit balance (after deductions from the account toward the cost of coverage) as of each Dec. 31 will be deemed to gain interest at the established interest rate. U.S. Bank has reserved the right to increase or decrease the interest rate.

Paying for coverage with credits

If your employment ended on or before Dec. 31, 2013, and you enrolled in the U.S. Bank Retiree Health Care Program, approximately two-thirds of the annual medical coverage cost will be offset by your accumulated credits, and you will pay the remaining approximately one-third out-of-pocket.

Approximately two-thirds of the medical cost will continue to be deducted from your credit balance until the credits are insufficient to cover two-thirds of the cost. The credit balance will be reviewed Jan. 1 of each year and if the credits will not cover two-thirds of the cost of your premium for the entire year, then the balance will be divided by twelve to determine the amount used to offset your premium payment. If your rate changes during the plan year, the dollar amount used to offset your premium payment will be recalculated. After your health care credit balance is depleted, you can continue to participate in the Program by paying 100% of the cost out-of-pocket.

If you elect coverage for dependents (spouse/domestic partner/children or grandchildren), the annual medical cost includes their coverage. Approximately two-thirds of the total elected coverage will be offset against the accumulated credits to the extent available.

If you die with accumulated credits

Any remaining credits can be transferred to an eligible spouse or domestic partner if you die while participating in the Program. Your spouse/domestic partner can use the credits for two-thirds of the annual cost of retiree health care coverage. This is the only use for the credits; he or she will not receive any cash payment or be able to use the credits for any other purpose. After the credits are depleted by the spouse/domestic partner, he or she can continue to participate in the Program by paying 100% of the cost.

Your spouse/domestic partner is the only dependent eligible for transferred credits; no non-spousal dependents receive transferred credits. However, if there are additional eligible dependents (such as a dependent child) receiving coverage at the time of your death, your spouse would continue to receive family coverage and the health care credits would continue to pay two-thirds of the cost until the credits are insufficient to cover two-thirds of the cost. Special payment rules apply in the year when the credits become insufficient to cover two-thirds of the cost. After your health care credit balance is depleted, your spouse/domestic partner and your covered dependents can continue to participate in the Program by paying 100% of the cost.

Plan highlights

This section applies to the Early Retiree Medical option only. If you are enrolled in the UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs, see the separate materials for the UnitedHealthcare Group Medicare Advantage (PPO) plan.

The following tables provide a summary of key information about the Early Retiree Medical option. See the information that follows the tables for important information about how the deductibles, coinsurance and maximums work. Also see the "Glossary" for definitions.

Early Retiree Medical option

	Network provider	Non-network provider
Deductible per plan year; combined pharmacy/medical; non-embedded	You pay: $2,000/person (applies only to You Only coverage level) $3,200/family	You pay: $3,100/person (applies only to You Only coverage level) $4,300/family
Coinsurance medical only, see "What's covered – pharmacy" for prescription drug coverage	You pay 25%	You pay 45%
Out-of-pocket maximum per plan year; combined pharmacy/medical; non-embedded	You pay: $5,000/person (applies only to You Only coverage level) $7,500/family	You pay: $11,200/person (applies only to You Only coverage level) $16,800/family
Option maximums	Annual or lifetime maximums apply to certain services; see "What's covered – medical" and "What's covered – pharmacy"	
Network provider and non-network provider deductibles, out-of-pocket maximums, annual maximums and lifetime maximums accumulate jointly; e.g., if you use a non-network provider, the amount applied to your non-network provider deductible also counts toward your network provider deductible, and vice versa.		

Deductibles and out-of-pocket maximums

A deductible is the amount of eligible expenses you must pay each plan year toward covered health services before you and the Program begin to share covered expenses. Amounts you pay toward your deductible – as well as copayments and coinsurance – are applied toward your out-of-pocket maximum.

The out-of-pocket maximum is the most you will pay toward covered health services each plan year. Once you reach the out-of-pocket maximum, the Program pays 100% of the eligible expenses for covered health services for the remainder of the year (subject to annual or lifetime maximum benefits for certain services).

The Early Retiree Medical option has a combined medical/pharmacy deductible and a combined medical/pharmacy out-of-pocket-maximum; they are non-embedded. They can be met by one covered family member or by a combination of covered family members. This means:

- If you cover just yourself, you only need to meet the per person amount.
- If you cover your family, you need to meet the family amount. The family amount can be met by one covered member or any combination of covered members. The per-person amounts do not apply.

Example 1: Sally is covered under the Early Retiree Medical option at the You Only coverage level. She must have eligible medical and/or pharmacy expenses of $2,000 before she and the Program begin to share covered expenses.

Example 2: Joe is covered under the Early Retiree Medical option at the Family level. He and his spouse must have combined eligible medical and/or pharmacy expenses of $3,200 before he and the Program begin to share covered expenses. The $2,000 individual deductible does not apply because Joe has a dependent enrolled in coverage.

Expenses that do not apply to your deductible

- Your monthly health care premiums.
- Any costs not covered by your option.
- Any amounts that exceed eligible expenses or the recognized amount (when applicable).
- Any amounts that exceed the plan's applicable prescription drug charge or out-of-network reimbursement rate when a non-network retail pharmacy is used for pharmacy services, when you do not present your ID card, or for covered compound prescriptions not submitted directly to Optum Rx by the pharmacy.
- Specialty drugs not filled by the designated Optum specialty pharmacy when required.
- Any maintenance medications not filled by Optum home delivery or a CVS retail pharmacy (84- to 90-day supply) after the first two fills when required.
- Certain coupons or offers from pharmaceutical manufacturers or affiliates.
- Any discount amounts associated with a copay assistance program for specialty medications.
- Any amounts covered 100% by the Program, including past-due amounts for mail order medications that are charged back to the plan.
- Ancillary or therapeutically equivalent charges described in "What's covered - pharmacy."
- For the Early Retiree Medical option, drugs on the Core Plus Preventive Drug List.

Expenses that do not apply to your out-of-pocket maximum

- Any cost difference between a brand-name drug and a generic equivalent when a brand-name drug is prescribed and a generic drug is available (once your deductible is met).
- The charges listed above that do not apply to your deductible also do not apply to your out-of-pocket maximum, except for drugs on the Core Plus Preventive Drug List for the Early Retiree Medical option.

These charges also are not eligible for any reimbursement once you meet your out-of-pocket maximum.

Copayments
Copayments (copays) are payments you make on a per service basis for covered health services. Copayments are applied to the out-of-pocket maximum. Any applicable prescription drug copays will be applied after the combined medical/pharmacy deductible has been satisfied, except for drugs on the Core Plus Preventive Drug List for the Early Retiree Medical option.

Coinsurance
Coinsurance is the percentage of the cost of a service (the lesser of eligible expenses or recognized amount when applicable, and the provider's actual billed charge) you pay for covered health services once you have satisfied your deductible. The coinsurance you pay is applied to the out-of-pocket maximum, except any cost difference between a brand-name drug and a generic equivalent when a brand-name drug is prescribed and a generic drug is available. Your coinsurance depends on your plan, the service received and if you use a network or non-network provider. If you receive services from a non-network provider, you pay the applicable coinsurance plus any amount in excess of eligible expenses. See "Networks" and "Advocacy Services" for more information. A change to the cost during a plan year will not result in a recalculation of any coinsurance paid.

What's covered – medical
Schedule of benefits
The information in this section applies to the Early Retiree Medical option only. This section does not apply to the UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs; refer to your plan materials.

Early Retiree Medical option
This table shows the coinsurance you pay after your deductible has been met for covered health services under the Early Retiree Medical option. Coinsurance is based on eligible expenses; you also pay any difference between the provider's billed charge and eligible expenses or recognized amount when applicable if using non-network providers; see "Networks" and "Advocacy Services." For detailed descriptions and any applicable limitations of your benefits, refer to "Additional coverage details" that follows this table. Covered health services in the table and additional coverage details section appear in the same order for easy reference. If a service is not listed, it is likely not a covered health service. Refer to "Coverage requirements, limitations and exclusions – medical" to see if any action is recommended or required on your part before receiving the service. Call UnitedHealthcare if you have questions about coverage for a specific procedure.

Covered health service	Network provider	Non-network provider
24/7 Virtual Visits Network benefits are available only when services are delivered through a 24/7 Virtual Visits Designated Virtual Network Provider found on myuhc.com.	You pay 25%	Not covered
Acupuncture services	You pay 25%	You pay 45%
Ambulance services – emergency only		

Covered health service	Network provider	Non-network provider
1. Ground ambulance 2. Air ambulance	You pay 25% You pay 25%	You pay 25% You pay 25%
Ambulance services – non-emergency 1. Ground ambulance 2. Air ambulance	 You pay 25% You pay 25%	 You pay 25% You pay 25%
Cancer services Services do not need to be received at a designated Cancer Resource Services (CRS) 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.	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.
Cellular and gene therapy	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.	Not covered
Clinical trials – routine patient care costs	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.	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.
Congenital heart disease services Services do not need to be received at a designated Congenital Heart Disease (CHD) Resource Services 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.	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.
Convenience clinic	You pay 25%	You pay 45%
Dental-related services 1. Accident-related 2. Cleft lip and palate 3. Dental hospital services	 You pay 25% You pay 25% You pay 25%	 You pay 45% You pay 45% You pay 45%
Diabetes services 1. Diabetes self-management training/diabetic eye examinations/foot care	Depending upon where the covered health service is provided, benefits will be the	Depending upon where the covered health service is provided, benefits will be the

Covered health service	Network provider	Non-network provider
	same as those stated under each covered health service category in this section.	same as those stated under each covered health service category in this section.
2. Diabetes equipment	Benefits for diabetes equipment will be the same as those stated under "Durable medical equipment" in this section.	Benefits for diabetes equipment will be the same as those stated under "Durable medical equipment" in this section.
3. Diabetes supplies	Diabetes supplies including syringes, needles, lancets and test strips are covered by Optum Rx. See "Diabetic supplies" and "Additional services – Livongo by Teladoc Health" for more information.	Diabetes supplies including syringes, needles, lancets and test strips are covered by Optum Rx. See "Diabetic supplies" and "Additional services – Livongo by Teladoc Health" for more information.
Durable medical equipment (DME) and medical supplies	You pay 25%	You pay 45%
Emergency health services - outpatient	You pay 25%	You pay 25%
Enteral nutrition	You pay 25%	You pay 45%
Eye examinations 1. Preventive	The plan pays 100%	Not covered
2. Non-preventive	You pay 25%	You pay 45%
Habilitative services	Depending upon where the covered health service is provided, benefits will be the same as those stated under "Rehabilitation services - outpatient therapy" and "Spinal treatment, chiropractic and osteopathic manipulative therapy" categories in this section.	Depending upon where the covered health service is provided, benefits for will be the same as those stated under "Rehabilitation services - outpatient therapy" and "Spinal treatment, chiropractic and osteopathic manipulative therapy" categories in this section.
Hearing aids	You pay 25%	You pay 45%
Home health care	You pay 25%	You pay 45%
Hospice care	You pay 25%	You pay 45%
Hospital – inpatient stay	You pay 25%	You pay 45%
Infertility services Services must be received at a designated Fertility Solutions provider.	Depending upon where the covered health service is provided, benefits will be the same as those stated under each covered health service	Not covered

Covered health service	Network provider	Non-network provider
For benefits related to the diagnosis and treatment of infertility caused by an underlying condition, see "Outpatient surgery, diagnostic and therapeutic services" and "Physician office services" in this section.	category in this section.	
Injections received in a physician's office 1. Preventive 2. Non-preventive	 The plan pays 100% You pay 25% per injection	 Not covered You pay 45% per injection
Maternity services 1. Hospital services 2. Prenatal office visits 3. Postpartum office visits	 You pay 25% The plan pays 100% The plan pays 100%	 You pay 45% You pay 45% You pay 45%
Mental health 1. Inpatient 2. Outpatient	 You pay 25% You pay 25%	 You pay 45% You pay 45%
Neonatal services Services do not need to be received at a designated Neonatal Resource Services (NRS) 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.	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.
Neurobiological disorders – Autism Spectrum Disorder services 1. Inpatient 2. Outpatient	 You pay 25% You pay 25%	 You pay 45% You pay 45%
Nutritional counseling	You pay 25%	You pay 45%
Obesity surgery Services must be received at a designated Bariatric Resource Services (BRS) 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.	Not covered
Ostomy supplies	You pay 25%	You pay 45%
Outpatient surgery,	You pay 25%	You pay 45% (no coverage for

Covered health service	Network provider	Non-network provider
diagnostic and therapeutic services		dialysis services)
Physician fees for surgical and medical services	You pay 25%	You pay 45%
Physician office services 1. Primary care 2. Specialist	 You pay 25% You pay 25%	 You pay 45% You pay 45%
Prescription drugs	See "What's covered - pharmacy"	See "What's covered - pharmacy"
Preventive care services	The Program pays 100%	Not covered
Prosthetic devices	You pay 25%	You pay 45%
Reconstructive procedures	You pay 25%	You pay 45%
Rehabilitation services – outpatient therapy Physical therapy/occupational (including cognitive rehabilitation) therapy/speech therapy/vision therapy/post cochlear implant aural therapy/pulmonary rehabilitation/cardiac rehabilitation	You pay 25%	You pay 45%
Skilled nursing facility/ inpatient rehabilitation facility services	You pay 25%	You pay 45%
Spinal treatment, chiropractic and osteopathic manipulative therapy	You pay 25%	You pay 45%
Substance-related and addictive disorders 1. Inpatient 2. Outpatient	 You pay 25% You pay 25%	 You pay 45% You pay 45%
Temporomandibular joint (TMJ) dysfunction	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.	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.
Transplantation services 1. Kidney transplants must be received at a UnitedHealthcare network provider or at a	Depending upon where the covered health service is provided, benefits will be the same as those stated under	Not covered

Covered health service	Network provider	Non-network provider
designated Transplant Resource Services (TRS) provider. All other transplantation services (except Cornea transplants) must be received at a designated (TRS) provider. 2. Cornea transplants are not required to be performed at a designated TRS provider for you to receive network benefits.	each covered health service category in this section. You pay 25%	 You pay 45%
Urgent care services	You pay 25%	You pay 45%
Urinary catheters	You pay 25%	You pay 45%

Additional coverage details

This section supplements the "Schedule of benefits" table above. While the table provides you with plan coverage levels for covered health services, this section includes detailed descriptions and any applicable limitations of your benefits. Covered health services in this section appear in the same order as the table above for easy reference. If a service is not listed, it is likely not a covered service. Refer to "Coverage requirements, limitations and exclusions – medical" to see if any action is recommended or required on your part before receiving the service. Call UnitedHealthcare if you have questions about coverage for a specific procedure.

24/7 Virtual Visits

Virtual care for covered health services that include 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 healthcare specialist, outside of a medical facility (e.g., from home or from work).

Network benefits are available only when services are delivered through a 24/7 Virtual Visits Designated Virtual Network Provider. You can find a 24/7 Virtual Visits Designated Virtual Network Provider at myuhc.com or by calling UnitedHealthcare at the number on your ID card.

Benefits are available for urgent on-demand health care delivered through live audio with video or audio-only technology for the treatment of acute, but non-emergency medical needs. However, not all medical conditions can be treated through virtual care. The 24/7 Virtual Visits Designated Virtual Network Provider will identify any condition for which treatment by in-person physician contact is needed.

Benefits under this section do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that are not a 24/7 Virtual Visits Designated Virtual Network Provider.

Acupuncture services

Acupuncture services for pain therapy when another method of pain management has failed and the service is performed by a provider in the provider's office, when the provider is either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of medicine;
- Doctor of osteopathy;
- Chiropractor; or
- Acupuncturist.

Where such benefits are available, acupuncture is a covered health service for the treatment of:

- Nausea of chemotherapy;
- Post-operative nausea; and
- Nausea of early pregnancy.

No coverage for therapeutic acupuncture, weight loss management, smoking cessation or other non-listed purposes.

Ambulance services – emergency only

Emergency ambulance transportation by a licensed ambulance service to the nearest hospital where emergency health services can be performed. Includes ground or air ambulance as deemed appropriate by UnitedHealthcare.

Eligible expenses for ground and air ambulance transport provided by a non-network provider will be determined as described under "Eligible expenses."

Ambulance services – non-emergency

Transportation by professional ambulance (not including air ambulance) between medical facilities.

Transportation by regularly-scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment as deemed appropriate by UnitedHealthcare.

Coverage also for prearranged medically necessary air or ground ambulance transportation requested by an attending physician or nurse. If UnitedHealthcare determines air ambulance was not medically necessary, but ground ambulance would have been medically necessary, UnitedHealthcare pays up to eligible expenses for ground ambulance. Prearranged air or ground ambulance transportation requested by an attending physician or nurse to any location is covered for end of life care.

Eligible expenses for ground and air ambulance transport provided by a non-network provider will be determined as described under "Eligible expenses."

Cancer services

Use of Cancer Resource Services (CRS) is recommended, but not required for coverage under the plan.

This program provides specialized consulting services on a limited basis, 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.

To access designated cancer centers in the CRS program, call CRS at 866-936-6002 prior to receiving services. Eligible oncology services rendered for the treatment of a condition that has a primary or suspected diagnosis related to cancer will be covered.

If the patient resides more than 50 miles from the designated provider, expenses for travel and lodging may be reimbursed. See "Travel and lodging" for more information.

See "Cancer Management Program" for additional resources available for all types of cancer.

Cellular and gene therapy

Benefits are available for cellular therapy and gene therapy received on an inpatient or outpatient basis at a hospital or on an outpatient basis at an alternate facility or in a physician's office.

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

Clinical trials – routine patient care costs

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.

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 you are 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:

- That would otherwise be covered absent a clinical trial;
- Required solely for the provision of the experimental or investigational service(s) or item, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Needed for reasonable and necessary care arising from the provision of an experimental or investigational service(s) or item.

Routine costs for clinical trials do not include:

- The experimental or investigational service(s) or item. The only exceptions to this are:
  - Certain Category B devices.
  - Certain promising interventions for patients with terminal illnesses.
  - Other items and services that meet specified criteria in accordance with UnitedHealthcare medical and drug policies.

- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

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

- 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), including National Cancer Institute (NCI).
  – Centers for Disease Control and Prevention (CDC).
  – Agency for Healthcare Research and Quality (AHRQ).
  – Centers for Medicare and Medicaid Services (CMS).
  – A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA).
  – A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  – The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the National Institutes of Health.
    - 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.

See “Cancer Management Program” for additional resources available for all types of cancer.

Congenital heart disease services

Use of Congenital Heart Disease (CHD) Resource Services is recommended, but not required for coverage under the plan.

The plan pays benefits for congenital heart disease surgeries which are ordered by a physician. Congenital heart disease surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding benefits for congenital heart disease services. To take part in the CHD Resource Services program, you or a covered dependent can call the number on your ID card or call CHD Resource Services directly at 866-534-7209 for information about these guidelines prior to receiving services.

If the patient resides more than 50 miles from the designated provider, expenses for travel and lodging may be reimbursed. See “Travel and lodging” for more information.

Dental-related services

Accidental dental

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

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

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

- Dental services related to medical transplant procedures;
- Initiation of immunosuppressive (medication used to reduce inflammation and suppress the immune system); and
- Direct treatment of acute traumatic injury, cancer or cleft palate.

Benefits are available only for treatment of a sound, natural tooth.

The physician or dentist must certify that the injured tooth was:

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

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

- Started within three months of the accident or if not enrolled in the plan at the time of the accident, within the first three months of coverage under the plan; and
- Completed within 12 months of the accident, or if not enrolled in the plan at the time of the accident, within the first 12 months of coverage under the plan.

Dental damage that results from normal activities of daily living or extraordinary use of the teeth is not considered an "accident" and is not covered.

Cleft lip and palate
Dental implants and orthodontia services provided as part of the treatment would be eligible.

Dental hospital services
Actual dental treatment not covered. Coverage only available for anesthesia, inpatient, and outpatient hospital charges when related to a medical condition and medically necessary to protect and safeguard the life of the patient who is a covered child under age five, is severely disabled, or has a medical condition that requires hospitalization or general anesthesia for dental treatment, as determined by UnitedHealthcare.

Diabetes services

Diabetes self-management training/diabetic eye examinations/foot care
Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a physician and provided by appropriately licensed or registered healthcare professionals.

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

Diabetes equipment
Insulin pumps and supplies for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under durable medical equipment (DME).

Benefits for diabetes equipment that meet the definition of DME are subject to the limit stated under "Durable medical equipment (DME) and medical supplies" in this section.

Benefits for insulin pumps and supplies that can only be obtained from a pharmacy are covered by Optum Rx as described in "What's covered – pharmacy."

Diabetes supplies
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 covered by Optum Rx. See "Diabetic supplies" and "Additional services – Livongo by Teladoc Health" for more information.

Durable medical equipment (DME) and medical supplies

The plan pays for DME that meets each of the following:

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

If more than one piece of DME can meet your functional needs, benefits are available only for the equipment that meets the minimum specifications for your needs.

Examples of DME include but are not limited to:

- Equipment to assist mobility, such as a standard wheelchair;
- A standard hospital-type bed;
- Oxygen concentrator units and the rental of equipment to administer oxygen;
- Delivery pumps for tube feedings;
- SADD lights;
- 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 “Outpatient surgery, diagnostic and therapeutic services” in this section;
- Foot orthotics (custom made orthopedic shoes, arch supports and foot orthotics) are covered. No coverage for over-the-counter products;
- Custom molded cranial orthotics (helmets) and cranial banding when prescribed by physician;
- Orthopedic devices covered under DME if DME criteria are met;
- Braces that stabilize an injured body part are considered DME and are a covered health service, 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 DME 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
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions.

UnitedHealthcare provides benefits for a single unit of DME (e.g., one insulin pump) and provides repair for that unit.

Benefits also include dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impairment 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 for repair/replacement are limited to once every three years.

Benefits are provided for the repair/replacement of a type of DME 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 your 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.

Benefits for medical supplies when prescribed and obtained from an eligible provider include:

- Supplies that are necessary for the effective use of the DME item/device (e.g., oxygen tubing or mask, or tubing for a delivery pump); and
- Medical supplies such as casts, splints, trusses, braces or crutches, and blood or blood plasma.

Benefits also are provided for disposable medical supplies when prescribed and obtained from an eligible provider. Disposable medical supplies only include surgical/compression stockings, including Jobst stockings and are limited to two pair per calendar year.

Emergency health services – outpatient

The plan pays for services that are required to stabilize or initiate treatment in an emergency. Emergency health services must be received on an outpatient basis at a hospital or alternate facility.

Network benefits will be paid for an emergency admission to a non-network hospital as long as UnitedHealthcare is notified within 48 hours of the admission or on the same day of admission if reasonably possible after you are admitted to a non-network hospital. 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, non-network benefits will apply.

Pharmaceuticals given while in the emergency room will be covered as medical claims. Written prescriptions to be filled when you leave the emergency room will be covered as pharmacy claims. See "What's covered – pharmacy" for more information.

Enteral nutrition

Benefits are provided for specialized enteral formulas administered either orally or by tube feeding for certain conditions under the direction of a physician.

Eye examinations

Preventive – Routine vision exams are covered as preventive care. You need to use a provider within the UnitedHealthcare network.

Non-preventive – Benefits provided for treatment of eye disease or injury. The plan also pays benefits for an Optomap retinal exam when performed and billed for a non-preventive reason.

Eyeglasses or contact lenses are covered only for the medical conditions keratoconus and ulcerative keratitis and post-cataract surgery (aphakia), accidental injury, or as a therapeutic bandage. Limited to one pair of eyeglasses or contact lenses after surgery paid by the plan. Thereafter, coverage applies only to lens replacement if prescription changes.

Habilitative services

For purposes of this benefit, "habilitative services" means medically necessary skilled healthcare services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is medically necessary to maintain your 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 to be delivered safely and effectively.
- It is not custodial care.

UnitedHealthcare 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 if you have a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist 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, educational/vocational training and residential treatment are not habilitative services. A service that does not help you to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

The plan may require medical records or other necessary data be provided to allow the plan to prove medical treatment is needed. When the treating provider expects that continued treatment is or will be required to allow you to achieve progress, the plan may request additional medical records.

Benefits for physical, occupational (including cognitive rehabilitation) and speech therapy are limited to 25 visits per plan year for each type of therapy unless additional visits are deemed medically necessary by UnitedHealthcare. These visit limits apply to network and non-network benefits combined. If additional visits are needed beyond the annual 25-visit maximum, ask your provider to submit medical notes to UnitedHealthcare for a medical necessity review before the 21st visit. If the services are considered necessary, additional visits will be covered until either the condition resolves or the end of the plan year – whichever comes first. If the services are determined to not be necessary, the services would not be covered once the plan's annual visit maximum has been reached and would be your responsibility.

Benefits for durable medical equipment and prosthetic devices, when used as a component of habilitative services, are described under "Durable medical equipment and medical supplies" and "Prosthetic devices" in this section.

No coverage for:

- Services primarily educational in nature, except as otherwise specified in this SPD.
- Services for or related to vocational rehabilitation (defined as services provided to an injured employee to assist the employee to return to either their former employment or a new position, or services to prepare a person with disabilities for employment), except when medically necessary and provided by an eligible healthcare provider.

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.

The hearing aid must be 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 the difference in cost.

Benefits also are provided for certain over-the-counter hearing aids for adults age 18 and older who have mild to moderate hearing loss.

Benefits for over-the-counter hearing aids do not require a medical exam, fitting by an audiologist or a written prescription.

Over-the-counter hearing aids must be purchased from UnitedHealthcare Hearing to receive the network level of benefits. If purchased elsewhere, the non-network level of benefits will apply.

Benefits are limited to $2,500 (including repairs/replacement) per hearing-impaired ear paid by the plan every three calendar years (prescribed and over-the-counter combined). This limit also applies to network and non-network benefits combined. No coverage for replacement of lost hearing aids.

For more information, call UnitedHealthcare Hearing at 866-926-6632 or visit uhchearing.com.

Benefits include bone-anchored hearing aids with no age or quantity limit. 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 when you have either of the following:

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

Home health care

Covered health services are services received from a home health agency that are both of the following:

- Ordered by a physician; and
- Provided by or supervised by a registered nurse in your home.

Benefits are available only when the home health agency services are provided on a part-time, intermittent schedule and when skilled care is required.

UnitedHealthcare 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.

Coverage is included for home infusion therapy. To be covered, care must be ordered by a physician and provided by a Medicare-approved or other pre-approved licensed home health agency. Covered services include solutions and pharmaceutical additives, pharmacy compounding and dispensing services, durable medical equipment and supplies, nursing services to train you or your caregiver to monitor your therapy, and collection, analysis and reporting of lab tests.

Services for custodial care, non-skilled care, services of a non-medical nature, private duty nursing, rest cures and mental health are not covered.

Hospice care

The plan pays benefits for hospice care that is recommended by a physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, respite and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a hospital.

There are no limits for hospice services rendered in the home. If in a skilled nursing facility, skilled nursing limits apply.

Hospital – inpatient stay

Hospital benefits are available for:

- Non-physician services and supplies received during the inpatient stay; and
- Room and board in a semi-private room (a room with two or more beds).

Infertility services

Enrollment in the Fertility Solutions program is required for retirees and their covered spouse/domestic partner to receive coverage for eligible infertility treatment, including prescription drugs. Coverage is not available for dependent children except for fertility preservation for medical reasons.

This program provides education, counseling, infertility management and access to a national network of premier infertility treatment clinics. Fertility Solutions must authorize your care in advance. Call 866-774-4626 to initiate authorization and enrollment before receiving infertility services and supplies.

All infertility services must be performed at a designated Fertility Solutions provider. Services not performed at a designated Fertility Solutions provider are not covered even if the services are medically necessary and/or referred. If the patient resides more than 60 miles from the designated provider, contact a Fertility Solutions case manager to determine an eligible network facility in your location prior to starting treatment. Other benefit limits and restrictions apply.

Coverage for infertility services in this section when provided by or under the direction of a physician are limited to the following procedures:

- Ovulation induction (or controlled ovarian stimulation).
- Insemination procedures: Artificial Insemination (AI) and Intrauterine Insemination (IUI).
- Assisted Reproductive Technologies (ART), including but not limited to in-vitro fertilization.
- Intracytoplasmic Sperm Injection (ICSI).
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm.
- Frozen embryo transfer cycle including the associated cryopreservation and storage of embryos.
- Surgical procedures: laparoscopy, lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, resection and ablation of endometriosis, transcervical tubal catheterization and ovarian cystectomy.
- Electroejaculation.
- Pre-implantation Genetic Testing for a Monogenic Disorder (PGT-M) or Structural Rearrangement (PGT-SR) when the genetic parents carry a gene mutation to determine whether that mutation has been transmitted to the embryo.
- Embryo biopsy for PGT-A used to select embryos for transfer in order to increase the chance for conception.
- Embryo transportation related network disruption.
- Known donor coverage: associated donor medical expenses, including collection and preparation of oocyte and/or sperm, and the medications associated with the collection and preparation of oocyte and/or sperm. The plan will not pay for donor charges associated with compensation or administrative services.
- Fertility preservation for medical reasons: when planned cancer or other medical treatment is likely to produce infertility/sterility, the plan covers the collection of sperm, cryopreservation of sperm, ovarian stimulation and retrieval of eggs, oocyte cryopreservation, in-vitro fertilization and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.

In addition, to be eligible for infertility benefits you must have a diagnosis of infertility. To meet the definition of infertility, you must meet one of the following:

- Females having failed to achieve a pregnancy after a year of regular, unprotected intercourse or therapeutic donor insemination under age 35, or after six months for age 35 or older.
- Females having failed to achieve or maintain a pregnancy due to impotence/sexual dysfunction.
- Females having infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.
- Males having a diagnosis of a male factor causing infertility (e.g., treatment of sperm abnormalities including the surgical recovery of sperm).
- You have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.
- Be under age 44 if female and using own oocytes (eggs), or be under age 55 if female and using donor oocytes (eggs). For treatment initiated prior to pertinent birthday, services will be covered to completion of initiated cycle.

The waiting period may be waived if you have a known male or female infertility factor, including but not limited to: congenital malformations, abnormal sperm, known ovulatory disorders, diminished

ovarian reserve, impotence/sexual dysfunction, moderate or severe endometriosis, or documented compromise of the fallopian tubes.

Artificial insemination with donor sperm is not subject to medical diagnosis criteria. Artificial insemination using donor sperm is limited to not more than 12 inseminations for females less than 35 years of age and not more than six inseminations for females 35 years of age and older. In this context, ovarian stimulation is not indicated, the insemination being performed in a natural cycle.

Certain criteria to be eligible for benefits may be waived for fertility preservation for medical reasons. In addition, child dependents are eligible for fertility preservation when planned cancer or other medical treatment is likely to produce infertility/sterility.

A $25,000 lifetime maximum paid by the plan per person will apply to all eligible infertility services, including medical and surgical treatment. A separate $10,000 lifetime maximum paid by the plan per person will apply to all eligible infertility prescription drugs. See “Coverage requirements, limitations and exclusions – pharmacy”.

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

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

Travel and lodging benefits are not available for Fertility Solutions.

Benefits related to the diagnosis and treatment of infertility caused by an underlying condition will be covered as shown in the “Outpatient surgery, diagnostic and therapeutic services” and “Physician office services” sections.

Benefits for certain pharmaceutical products, including specialty 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 are described under the “Injections received in a physician’s office” section below.

Benefits for pharmaceutical products for outpatient use that are filled by prescription order or refill are provided as described in “What’s covered - pharmacy”.

Injections received in a physician’s office

Preventive

The plan pays benefits for injections received in a physician’s office when no other heath service is received. Benefits are included for standard immunization vaccines recommended by the Advisory Committee on Immunization Practices (ACIP).

Non-preventive

The plan pays benefits for injections received in a physician's office when no other heath service is received, for example allergy immunotherapy, growth hormone therapy, Rabies and Vaccinia (Smallpox). Rabies and Vaccina (Smallpox) are not covered if needed for travel.

Pharmaceutical products
The plan also pays for pharmaceutical products that are administered on an outpatient basis in a hospital, alternate facility, physician's office, or in a covered person's home. Examples of what would be included under this category are antibiotic injections in the physician's office or inhaled medication in an urgent care center for treatment of an asthma attack.

Benefits under this section are provided only for pharmaceutical products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the pharmaceutical product is administered, benefits will be provided for administration of the pharmaceutical product under the corresponding benefit category in this SPD. Benefits for medication normally available by prescription order or refill are provided as described in "What's covered – pharmacy." Benefits under this section also 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 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 the number on your ID card.

Maternity
Pregnancy coverage ends when your coverage under your plan otherwise ends for any reason. New dependents must be added within 60 days of birth to be covered.

There is a special prenatal program to help during pregnancy. To sign up, you should notify UnitedHealthcare during the first trimester, but no later than one month prior to the anticipated childbirth. See the "Maternity Support Program" for additional resources available to you. It is completely voluntary and there is no extra cost for participating in the program.

No coverage for adoption or adoption-related expenses, surrogate pregnancy or related expenses, childbirth classes or delivery at home.

Under the Newborns' and Mothers' Health Protection Act of 1996, benefits may not be restricted for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or less than 96 hours following Cesarean section delivery.

You cannot be required to obtain prior authorization from your plan for your 48-hour or 96-hour stay to be covered. However, authorization is recommended from your plan beyond the applicable 48-hour or 96-hour stay. See "Coverage requirements, limitations and exclusions – medical" for more information about the notification process.

The law allows you and your baby to be released earlier than these time periods only if the attending provider decides, after consulting with you, that you and your baby can be discharged earlier. In any case, the attending provider cannot receive incentives or disincentives to discharge you or your baby earlier than 48 hours (or 96 hours).

Hospital services
The deductible for the facility and physician fees for the newborn will be waived while the mother remains inpatient (except for physician fees for a circumcision). Once the mother is discharged, the newborn's facility and physician fees will be subject to the newborn's own deductible and coinsurance if the newborn remains inpatient.

Prenatal lab and x-ray services
Prenatal lab and x-ray services are paid based on the billing codes used by your provider on the claim submitted to UnitedHealthcare for payment. If billed as in a facility, they pay under the hospital services benefit. If billed as in an office, they pay under the prenatal office visits benefit.

Mental health

Benefits include the following levels of care:

- Inpatient treatment.
- Residential treatment.
- Partial hospitalization/day treatment.
- Intensive outpatient treatment.
- Outpatient treatment.
- Office visits.

Inpatient treatment and residential treatment includes room and board in a semi-private room (a room with two or more beds).

Covered services include:

- Diagnostic evaluations, assessment and treatment and/or procedures.
- Medication management.
- Individual, family and group therapy.
- Crisis intervention.

Neonatal services

Use of Neonatal Resource Services (NRS) is recommended, but not required for coverage under the plan.

This program 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 number on your ID card or call NRS directly at 866-534-7209.

Travel and lodging benefits are not available for NRS.

Neurobiological disorders – Autism Spectrum Disorder services

The plan pays for behavioral services for Autism Spectrum Disorder including intensive behavioral therapies such as Applied Behavior Analysis (ABA) at the same level of benefits as other mental health services that are the following:

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

These benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a covered health service for which benefits are available under the applicable medical covered health services categories as described in this section. Physical, occupational and speech therapy services for Autism Spectrum Disorders will be covered as shown in the "Rehabilitation services – outpatient therapy" section.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential treatment.
- Partial hospitalization/day treatment.
- Intensive outpatient treatment.
- Outpatient treatment.

Inpatient treatment and residential treatment includes room and board in a semi-private room (a room with two or more beds).

Covered services include:

- Diagnostic evaluations, assessment and treatment and/or procedures.
- Medication management.
- Individual, family and group therapy.
- Crisis intervention.

Nutritional counseling

The plan will pay for covered health services provided by a registered dietician in an individual session if you have medical conditions that require a special diet. Some examples of such medical conditions include:

- Diabetes mellitus;
- Coronary artery disease;
- Congestive heart failure;
- Severe obstructive airway disease;
- Gout (a form of arthritis);
- Renal failure;
- Phenylketonuria (a genetic disorder diagnosed at infancy);
- Anorexia; and
- Hyperlipidemia (excess of fatty substances in the blood).

Dietary counseling is also considered a covered item following an eligible obesity surgery procedure. The patient's treatment plan includes pre- and post-operative dietary evaluations. Pre- and post-operative dietary evaluations are defined as evaluations conducted by a dietician/nutritionist.

The plan pays for medical or behavioral/mental health related 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 include:

- Nutritional education is required for a disease in which patient self-management is a part of treatment.
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

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

No coverage for individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences.

Obesity surgery

Use of Bariatric Resource Services (BRS) is required for coverage under the plan.

For obesity surgery services to be considered covered health services under the BRS program, you must contact BRS and speak with a nurse consultant prior to receiving services. Call 888-936-7246 to initiate authorization and enrollment as soon as the possibility of an obesity surgery arises and before a pre-surgical evaluation is performed.

The Plan covers surgical treatment of morbid obesity provided by or under the direction of a physician provided either of the criteria is met:

- You have a minimum Body Mass Index (BMI) of 40;
- You have a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by obesity.
- You are 18 years or older;

- You have completed a three-month physician supervised weight loss program within the last two years; and
- You have completed a pre-surgical psychological evaluation within 12 months of surgery.

All obesity surgeries must be performed at a designated BRS provider. Services not performed at a designated BRS provider are not covered even if the services are medically necessary and/or referred. Other benefit limits and restrictions apply.

If the patient resides more than 50 miles from the designated provider, expenses for travel and lodging may be reimbursed. See “Travel and lodging” for more information.

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

Ostomy supplies

Benefits for ostomy supplies when prescribed and obtained from an eligible provider are limited to:

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

Outpatient surgery, diagnostic and therapeutic services

The plan pays for covered health services for surgery and related services received on an outpatient basis at a hospital or alternate facility. Benefits include only the facility charge and the charge for supplies and equipment. Benefits for the surgeon fees and facility-based physician's fees related to outpatient surgery are described under Physician fees for surgical and medical services. When these services are performed in a physician's office, benefits will be paid as described under “Physician office services.”

The plan pays for upper and lower jawbone surgery (orthognathic surgery) in accordance with UnitedHealthcare standard coverage guidelines.

The plan pays for elective and non-elective abortions in accordance with applicable law.

The plan pays for non-preventive outpatient diagnostic lab, radiology and x-ray covered health services received on an outpatient basis at a hospital or alternate facility. When these services are performed in a physician's office, benefits are described under “Physician office services.” Services are paid based on the billing codes used by your provider on the claim submitted to UnitedHealthcare for payment. Benefits for preventive services are paid as described under “Preventive care services.”

The plan pays for presumptive drug tests and definitive drugs tests. Both tests are limited to 18 per year, network and non-network combined.

The plan pays for sleep studies performed in a network facility or medically appropriate sleep studies done in a patient’s home. No coverage for non-network sleep studies, SNAP studies or for overnight pulse oximetry to screen patients for sleep apnea.

The plan pays for covered health services for CT scans, PET scans, MRI, and nuclear medicine received on an outpatient basis at a hospital or alternate facility. Benefits include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.

The plan pays for covered health services for therapeutic treatments received on an outpatient basis at a hospital or alternate facility, including network dialysis services, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above. Benefits include the facility charge, the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a physician's office, benefits will be paid as described under "Physician office services".

Physician fees for surgical and medical services

The plan pays for physician fees for surgical procedures and other medical care received in a hospital, skilled nursing facility, inpatient rehabilitation facility or alternate facility.

Covered health services provided by a non-network physician in certain network facilities will apply the same deductible, coinsurance, or copay as if the services were provided by a network provider. However, see "Eligible expenses" for more information on how this will be determined.

Physician office services

Benefits are paid by the plan for covered health services received in a physician's office for the evaluation and treatment of a sickness or injury. Benefits are provided under this section regardless of whether the physician's office is free-standing, located in a clinic or located in a hospital. Services are paid based on the billing codes used by your provider on the claim submitted to UnitedHealthcare for payment. Benefits for preventive services are described under "Preventive care services."

Benefits under this section include hearing exams in case of sickness or injury.

Covered health services include genetic counseling. Benefits are available for genetic testing which is determined to be medically necessary following genetic counseling when ordered by the physician.

Any prescription written by your provider to be filled at a pharmacy will be covered by Optum Rx, not UnitedHealthcare. See "What's covered – pharmacy."

Primary care

The primary care physician (PCP) copay applies to a physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general practice. Behavioral health providers are included within the primary care physician (PCP) copay.

Specialist

The specialist (SPEC) copay applies to a physician with a concentration of training in a specific branch of medicine other than those listed for a primary care physician. The SPEC copay also applies to a physician assistant or nurse practitioner billing under their own contract or tax identification number.

Pre-existing conditions

The Early Retiree Medical option does not impose pre-existing condition limitations. This means that if you or your dependents have a pre-existing condition when enrolling in the Early Retiree Medical option, all eligible services related to the pre-existing condition will be covered without restriction, assuming the condition itself is covered.

Preventive care

As required by law, eligible preventive care services received from a network provider are not subject to a deductible and are paid 100% by the plan with no cost to you. Services received from a non-network provider are not covered.

Visit uhc.com/health-and-wellness/preventive-care for preventive care services based on age and gender. The table below includes additional details for covered preventive care services. Call UnitedHealthcare if you have questions. Also, see "What's covered – pharmacy" regarding coverage of preventive care medications.

Service	Criteria
Breast feeding services and supplies	Costs for breastfeeding equipment include manual or personal-use electric breast pumps when purchased from an eligible provider in conjunction with each birth; check with UnitedHealthcare for details
Colorectal cancer screening	Colorectal cancer screenings are covered for adults age 45 through 75 years when the claim is submitted with a primary preventive diagnosis code. Fecal DNA (Cologuard) screenings for adults age 45 through 75 years are covered once every three years.
Human Immunodeficiency Virus (HIV) infection screening	HIV screenings are covered for adolescents and adults aged 15-65 years old; younger adolescents and older adults who are at increased risk of infection; and all pregnant persons, including those who present in labor or at delivery whose HIV status is unknown. The screening includes education and risk assessment as part of the preventive exam.
Mammography screening	Mammography screenings are covered when the claim is submitted with preventive screening procedure codes, regardless of age.
Prevention of Human Immunodeficiency Virus (HIV): Pre-exposure prophylaxis (PrEP)	PrEP with effective antiretroviral therapy is covered for those at high risk of HIV acquisition. Coverage includes labs, testing and monitoring. See "What's covered – pharmacy" regarding preventive medications covered by Optum Rx.

Covered services generally include:

- Evidence-based recommended items or services that have a rating of “A” or “B” from the U.S. Preventive Services Task Force (USPSTF);
- Immunizations recommended from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC); and
- Evidence-informed preventive care and screenings for infants, children, adolescents and women provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

Coverage for a service is driven by the code(s) billed by your provider. This is because your provider determines the nature of your visit and whether there is a current medical issue prompting your visit. Even though preventive care is covered at 100%, you may be responsible for a portion of the preventive care visit cost when:

- The service is not billed as preventive care, even if you received the service during your preventive care visit;
- You do not meet the criteria (based on age or population) for the recommendation or guideline for the preventive care service; or
- The preventive care service was received from a non-network provider.

Example: Linda visits the doctor for an annual checkup. She receives diabetes lipid profiles. These services are considered preventive care because she has not been diagnosed with diabetes. At the same visit, she also talks with her doctor about and receives care for her ongoing back pain. This part of the visit is not considered preventive care so Linda is responsible for paying for that part of the visit if she has not yet met her deductible.

Prosthetic devices

Benefits are paid by the plan for prosthetic devices that replace a limb or body part including:

- Artificial limbs;
- Artificial eyes; and
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998.

Benefits also are provided for one wig per calendar year for scalp/head wounds, burns, injury, Alopecia Areata, cancer, and if you’re undergoing chemotherapy or radiation therapy.

If more than one prosthetic device can meet your functional needs, benefits are available only for the prosthetic device that meets the minimum specifications for your needs.

The prosthetic device must be ordered or provided by, or under the direction of a physician. UnitedHealthcare provides benefits for a single purchase, including repairs, of a type of prosthetic device. 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 your 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.

Reconstructive procedures

Reconstructive procedures are services performed when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part. By improving or restoring physiologic function it is meant that the target 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.

Liposuction for lipedema is covered.

Panniculectomy is covered when both chronic, recurrent infection is documented and interference with hygiene and activities of daily living are documented.

Procedures are services considered cosmetic procedures when they improve appearance without making an organ or body part work better. The fact that a person may suffer psychological consequences from the impairment does not classify surgery and other procedures done to relieve such consequences as a reconstructive procedure. Reshaping a nose with a prominent "bump" would be a good example of a cosmetic procedure because appearance would be improved, but there would be no effect on function like breathing. The plan does not provide benefits for cosmetic procedures.

Some services are considered cosmetic in some circumstances and reconstructive in others. This means that there may be situations in which the primary purpose of the service is to make a body part work better, whereas in other situations, the purpose would be to improve appearance and function (such as vision) is not affected. A good example is upper eyelid surgery. At times, this procedure will improve vision, while on other occasions improvement in appearance is the primary purpose of the procedure.

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 mandated 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 covered health service. You can contact UnitedHealthcare at the number on your ID card for more information about benefits for mastectomy-related services.

No coverage for psychological or emotional reasons. No coverage for repair of scars and blemishes on skin surfaces or cosmetic, reconstructive or plastic surgery for any other purpose.

Rehabilitation services – outpatient therapy

Rehabilitation services must be performed by a licensed therapy provider, under the direction of a physician. Benefits under this section include rehabilitation services provided 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. When these services are performed in a physician's office, benefits are paid as described under “Physician office services.”

The Plan provides short-term outpatient rehabilitation services for:

- Physical therapy;
- Occupational (including cognitive rehabilitation) therapy;
- Speech therapy;
- Vision therapy;
- Post cochlear implant aural therapy;
- Pulmonary rehabilitation; and
- Cardiac rehabilitation.

For outpatient rehabilitation services for speech therapy, the plan will pay benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from injury, stroke, cancer or 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 under this section are not available for maintenance/preventive treatment.

Benefits for cardiac rehabilitation are limited to 36 visits per plan year unless additional visits are deemed medically necessary by UnitedHealthcare. This visit limit applies to network and non-network benefits combined. If additional visits are needed beyond the annual 36-visit maximum, ask your provider to submit medical notes to UnitedHealthcare for a medical necessity review before the 32nd visit. If the services are considered necessary, additional visits will be covered until either the condition resolves or the end of the plan year – whichever comes first. If the services are determined to not be necessary, the services would not be covered once the plan’s annual visit maximum has been reached and would be your responsibility.

Benefits for physical, occupational (including cognitive rehabilitation) and speech therapy are limited to 25 visits per plan year for each type of therapy unless additional visits are deemed medically necessary by UnitedHealthcare. These visit limits apply to network and non-network benefits combined. If additional visits are needed beyond the annual 25-visit maximum, ask your provider to submit medical notes to UnitedHealthcare for a medical necessity review before the 21st visit. If the services are considered necessary, additional visits will be covered until either the condition resolves or the end of the plan year – whichever comes first. If the services are determined to not be necessary, the services would not be covered once the plan’s annual visit maximum has been reached and would be your responsibility.

Benefits for pulmonary rehabilitation are limited to 30 visits per plan year unless additional visits are deemed medically necessary by UnitedHealthcare. This visit limit applies to network and non-network benefits combined. If additional visits are needed beyond the annual 30-visit maximum, ask your provider to submit medical notes to UnitedHealthcare for a medical necessity review before the 26th visit. If the services are considered necessary, additional visits will be covered until either the condition resolves or the end of the plan year – whichever comes first. If the services are determined

to not be necessary, the services would not be covered once the plan's annual visit maximum has been reached and would be your responsibility.

No coverage for:

- Physical, occupational (including cognitive rehabilitation) and speech therapy services for learning disabilities and disorders, except when medically necessary and provided by an eligible healthcare provider.
- Services for or related to recreational therapy (defined as the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional and/or social disadvantages); educational therapy (defined as special education classes, tutoring, and other non-medical services normally provided in an educational setting); or forms of non-medical self-care or self-help training; including, but not limited to: health club memberships; aerobic conditioning; therapeutic exercises; work-hardening programs; etc., and all related material and products for these programs.
- Services for or related to therapeutic massage and rolfing (holistic tissue massage).
- Services for or related to rehabilitation services that are not expected to make measurable or sustainable improvement within a reasonable period of time, unless they are medically necessary and part of specialized maintenance therapy for the person's condition.
- Custodial care.

Skilled nursing facility/inpatient rehabilitation facility services

The plan pays for covered health services for an inpatient stay in a skilled nursing facility or inpatient rehabilitation facility. Benefits are available for:

- Services and supplies received during the inpatient stay; and
- Room and board in a semi-private room (a room with two or more beds).

Benefits in a skilled nursing facility are limited to 100 days per plan year. This limit applies to network and non-network benefits combined. Inpatient rehabilitation facility not subject to the 100-day maximum, only skilled nursing facility.

In general, the intent of skilled nursing is to provide benefits if you are convalescing from an injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation and facility services which are less than those of a general acute hospital but greater than those available in the home setting.

You are expected to improve to a predictable level of recovery. Benefits are available when skilled nursing and/or rehabilitation services are needed on a daily basis. Accordingly, benefits are not available when these services are considered intermittent care (such as physical therapy three times a week).

Benefits are not available for custodial, maintenance or domiciliary care (including administration of enteral feeds) which, even if it is ordered by a physician, is primarily for the purpose of meeting your personal needs or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

Custodial, maintenance or domiciliary care is not covered because it may be provided by persons without special skill or training. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, eating and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs.

Spinal treatment, chiropractic and osteopathic manipulative therapy

Benefits for spinal treatment include chiropractic and osteopathic manipulative therapy. Benefits for spinal treatment when provided by a spinal treatment provider in the provider's office.

Benefits include diagnosis and related services and are limited to one visit and treatment per day. In addition, spinal treatment is limited to 25 visits per plan year. This visit limit applies to network and non-network benefits combined.

The plan excludes any type of therapy, service or supply including, but not limited to spinal manipulations by a chiropractor or other physician for the treatment of a condition when the therapy, service or supply ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

Substance-related and addictive disorders coverage

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).

Covered services include:

- Diagnostic evaluations, assessment and treatment and/or procedures.
- Medication management.
- Individual, family and group therapy.
- Crisis intervention.

Temporomandibular joint (TMJ) services

The plan pays for covered health services for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a physician. Coverage includes necessary diagnostic or surgical treatment required as a result of accident, trauma, congenital defect, developmental defect, or pathology.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations. Benefits for surgical services also include U.S. Food and Drug Administration (FDA)-approved TMJ implants only when all other treatment has failed.

Benefits for an inpatient stay in a hospital and hospital-based physician services will be paid as described under “Hospital – inpatient stay” and “Physician fees for surgical and medical services” respectively.

Transplantation services

Use of Transplant Resources Services (TRS) is required for coverage under the plan (except cornea and kidney transplants).

This program provides access to specialized network facilities. TRS must authorize your care in advance. Call 888-936-7246 to initiate authorization and enrollment as soon as the possibility of a transplant arises and before a pre-transplantation evaluation is performed.

Covered health services include organ and tissue transplants including CAR-T cell therapy for malignancies when ordered by a network physician that are not an experimental, investigational service or unproven service. Examples of transplants for which benefits are available include, but are not limited to: bone marrow including CAR-T cell therapy for malignancies, kidney, cornea, heart, lung(s), or heart and lung(s), small bowel, liver, or liver and small bowel, pancreas, and pancreas if in conjunction with a kidney transplant. There is no coverage for animal organs. Contact UnitedHealthcare for information about living donor transplant coverage.

All transplants (except cornea and kidney transplants) must be performed at a designated TRS provider. Services not performed at a designated TRS provider are not covered even if the services are medically necessary and/or referred. Other benefit limits and restrictions apply.

Kidney transplants must be performed at a UnitedHealthcare network facility or at a designated TRS provider. Services not performed at a UnitedHealthcare network facility or at a designated TRS provider are not covered even if the services are medically necessary and/or referred. Other benefit limits and restrictions apply.

Benefits also are available for cornea transplants. You are not required to obtain prior authorization from UnitedHealthcare for a cornea transplant, nor is the cornea transplant required to be performed at a designated TRS provider. Cornea transplants must be performed at a UnitedHealthcare network facility in order to receive the network level of benefits. If performed at a non-network facility, the non-network level of benefits will apply.

Expenses for travel and lodging may be reimbursed if the transplant recipient resides more than 50 miles from the designated TRS provider (including kidney transplants). See “Travel and lodging” for more information. Kidney transplants performed at a UnitedHealthcare network facility are not eligible for travel and lodging reimbursement. Cornea transplants are not eligible for any travel and lodging reimbursement.

Travel and lodging

Travel and lodging are 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.

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

Travel and lodging expenses
The plan covers expenses for travel and lodging that is primarily for and essential to the receipt of the medical care for the patient 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, including when a child is the patient.
- The eligible expenses for lodging for the patient (while not hospitalized inpatient) and one companion.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the designated provider.
- Cancer services, congenital heart disease services, obesity surgery and transplantation services provide a combined overall lifetime maximum of $10,000 per covered person for all transportation and lodging expenses incurred by the patient and companion(s) and reimbursed under the plan in connection with all qualified procedures.

UnitedHealthcare must receive valid receipts for such expenses before you will be reimbursed and the expenses are subject to the plan deductible. Reimbursement will be made after the expense forms have been completed and submitted with the appropriate receipts. Reimbursement is as follows:

Lodging

- A per diem rate, up to $50 per day, for the patient (when not in the hospital) or the caregiver (if the patient is in the hospital).
- A per diem rate, up to $100 per day, for the patient and one caregiver. When a child is the patient, two persons may accompany the child, but the per diem rate will not change.

Examples of lodging 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 and 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

Urinary catheters

Benefits for external, indwelling and intermittent urinary catheters for incontinence or retention when prescribed and obtained from an eligible provider. Benefits include related urologic supplies for indwelling catheters limited to:

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

Women's Health and Cancer Rights Act of 1998

In accordance with this act – which requires group health plans that cover mastectomies to also cover certain mastectomy-related benefits or services, this plan covers the following with the same deductibles and coinsurance as any other illness:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction on the other breast to produce a symmetrical appearance; and
- Prostheses and approved treatment of physical complications (including lymphedemas) at all stages of the mastectomy.

See "Cancer Management Program" for additional resources available for all types of cancer.

Additional services – UnitedHealthcare

Cancer Management Program

This program identifies, assesses, and supports members who have any type of cancer and may include calls from a registered nurse who is a specialist in cancer and free educational information through the mail. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to advise you and to help you manage your condition. This program will work with you and your physicians, as appropriate, to offer education on cancer, and self-care strategies and support in choosing treatment options. If you think you may be eligible to participate or would like additional information, call the number on your ID card.

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 and hip replacement.
- Prostate disease.
- Prostate cancer.
- Benign uterine conditions.
- Breast cancer.
- Coronary disease.
- Bariatric surgery.

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

Maternity Support Program
Participation in this program is available to members* who are pregnant or thinking about becoming pregnant. It includes valuable educational information, advice and comprehensive case management.

Your enrollment in the program will be handled by an OB nurse who is assigned to you. To take full advantage of the program, 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.

*Members under age 18 can only be enrolled if a parent/legal guardian calls in to enroll the dependent or if the parent/legal guardian is present when the dependent calls in to enroll.

Personal Health Support Program
This program is 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 healthcare needs, UnitedHealthcare may assign to you 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 dependents receive appropriate medical care. When UnitedHealthcare is contacted by you or your provider, a Personal Health Support nurse will work with you to provide information about additional services that are available to you, such as disease management programs, health education and patient advocacy.

Program components are subject to change without notice and currently include:
- **Admission counseling** – Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on your ID card for support.

- **Inpatient care management** – If you are hospitalized, a nurse will work with your physician to make sure you are getting the care you need and that your physician's treatment plan is being carried out effectively.
- **Readmission management** – This program serves as a bridge between the hospital and your home if you are at high risk of being readmitted. After leaving the hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support nurse will also share important healthcare 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 healthcare 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 healthcare information related to the participant's specific chronic or complex condition.

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

Real Appeal program
UnitedHealthcare provides the Real Appeal program, a practical solution for weight-related conditions with the goal of helping people at risk from obesity-related diseases and those who want to maintain a healthy lifestyle. This program is designed to support individuals 18 years of age or older. This intensive, multi-component behavioral intervention provides a 52-week virtual approach that includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

This program will be individualized and may include, but is not limited to, the following:
- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change guidance and counseling by a specially trained health coach for clinical weight loss.

Participation is completely voluntary and without any additional charge. There are no deductibles, copays or coinsurance you must meet or pay for when services are received as part of the Real Appeal program. To participate or for more information, call Real Appeal at 844-924-REAL (844-924-7325). TTY users can dial 711 or visit usbank.realappeal.com.

Second opinion service
2nd.MD is a voluntary second opinion service that provides access to experienced specialists virtually (via phone or video conference) for education and guidance on:
- New diagnoses
- Surgeries or procedures
- Questions about treatment plans and medications

- Ongoing chronic conditions

A dedicated nurse will oversee medical records collection, selection, and scheduling with a post-consultation support.

To confidentially speak to 2nd.MD, call 866-269-3534. Participation is voluntary and free.

Stop smoking program

U.S. Bank is committed to providing the help you need to quit smoking by offering the stop smoking program to individuals age 18 and older who are enrolled in the Early Retiree Medical option (including retirees and dependents). Participation is voluntary and free. Learn more by contacting UnitedHealthcare at the number on the back of your ID card.

Coverage requirements, limitations and exclusions – medical

Prior authorization

UnitedHealthcare requires prior authorization for certain covered health services. In general, network providers are responsible for obtaining prior authorization before they provide these services to you.

Network facilities and network providers cannot bill you for services they fail to prior authorize as required. You can contact UnitedHealthcare by calling the number on your ID card.

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.

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, healthcare 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.

When you seek prior authorization as required, UnitedHealthcare 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.

You are required to obtain prior authorization for the following non-network services:

- **Ambulance** – non-emergent air ambulance.
- **Cardiac rehabilitation** – If additional visits will be needed beyond the plan's annual 36-visit maximum, ask your provider to submit medical notes to UnitedHealthcare for a medical necessity review before the 32nd visit. If the services are considered necessary, additional visits will be covered until either the condition resolves or the end of the plan year – whichever comes first. If

the services are determined to not be necessary, the services would not be covered once the plan's annual visit maximum has been reached and would be your responsibility.

- **Clinical trials**.
- **Congenital heart disease surgery**.
- **Dental treatment requiring hospitalization or general anesthesia** for a covered person who is under age five, is severely disabled or has a medical condition.
- **Durable medical equipment** or orthotic for items that will cost more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item), including diabetes equipment for the management and treatment of diabetes.
- **Growth hormone therapy**.
- **Home health care** for nutritional foods.
- **Hospice care** – inpatient.
- **Hospital inpatient stay**. Prior authorization/notification for scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a Cesarean section delivery. You should call UnitedHealthcare before any additional services that need prior authorization are received.
- **Lab, x-ray and diagnostics** – genetic testing, CT, PET scans, MRI, MRA, nuclear medicine (including nuclear cardiology), stress echocardiography and transthoracic echocardiogram.
- **Mental health services** including: inpatient services (including services at a residential treatment facility); partial hospitalization/day treatment; intensive outpatient treatment programs; outpatient electro-convulsive treatment; psychological testing; and transcranial magnetic stimulation. You should obtain prior authorization with Optum Behavioral Solutions five business days before a scheduled admission by calling the customer service number on your ID card or before receiving any treatment or supply for mental health. Optum Behavioral Solutions takes calls seven days a week, 24 hours a day. For non-scheduled services, you should obtain prior authorization one business day before services are received (or as soon as reasonably possible). For non-elective admissions, provide notification within 48 hours (or as soon as reasonably possible).
- **Neurobiological disorders - Autism Spectrum Disorder services** including: inpatient services (including services at a residential treatment facility); partial hospitalization/day treatment; intensive outpatient treatment programs; psychological testing; and intensive behavioral therapy, including Applied Behavior Analysis (ABA). You should obtain prior authorization with Optum Behavioral Solutions five business days before a scheduled admission by calling the customer service number on your ID card or before receiving any treatment or supply for Autism Spectrum Disorders. Optum Behavioral Solutions takes calls seven days a week, 24 hours a day. For non-scheduled services, you should obtain prior authorization one business day before services are received (or as soon as reasonably possible). For non-elective admissions, provide notification within 48 hours (or as soon as reasonably possible).
- **Occupational (including cognitive rehabilitation), physical and speech therapy** – If additional visits will be needed beyond the plan's annual 25-visit maximum, ask your provider to submit medical notes to UnitedHealthcare for a medical necessity review before the 21st visit. If the services are considered necessary, additional visits will be covered until either the condition resolves or the end of the plan year – whichever comes first. If the services are determined to not be necessary, the services would not be covered once the plan's annual visit maximum has been reached and would be your responsibility.
- **Prosthetic devices** for items that will cost more than $1,000 per device.

- **Pulmonary rehabilitation** – If additional visits will be needed beyond the plan's annual 30-visit maximum, ask your provider to submit medical notes to UnitedHealthcare for a medical necessity review before the 26th visit. If the services are considered necessary, additional visits will be covered until either the condition resolves or the end of the plan year – whichever comes first. If the services are determined to not be necessary, the services would not be covered once the plan's annual visit maximum has been reached and would be your responsibility.
- **Reconstructive procedures**, including breast reconstruction surgery following mastectomy and breast reduction surgery.
- **Skilled nursing facility/inpatient rehabilitation facility services**.
- **Substance-related and addictive disorders services**, including: inpatient services (including services at a residential treatment facility); partial hospitalization/day treatment; intensive outpatient treatment programs; and psychological testing. You should obtain prior authorization with Optum Behavioral Solutions five business days before a scheduled admission by calling the number on your ID card or before receiving any treatment or supply for substance-related and addictive disorders. Optum Behavioral Solutions takes calls seven days a week, 24 hours a day. For non-scheduled services, you should obtain prior authorization one business day before services are received (or as soon as reasonably possible). For non-elective admissions, provide notification within 48 hours (or as soon as reasonably possible).
- **Surgery** – sleep apnea surgeries, bone-anchored hearing aid, cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant.
- **Therapeutics** – IV infusion, intensity modulated radiation therapy and MR-guided focused ultrasound.

This list is not exhaustive and is subject to change. Prior authorization does not apply if Medicare is the primary payer for you or a covered dependent, except for obesity surgery and transplants. To verify if it's recommended you obtain prior authorization for your service, contact UnitedHealthcare at the number on your ID card.

Unless stated otherwise in the list above, you should:

- Obtain prior authorization five business days before admission or services are received for a scheduled admission or scheduled services;
- Obtain prior authorization one business day before services are received (or as soon as reasonably possible) for non-scheduled services; and
- Provide notification within 48 hours (or as soon as reasonably possible) for non-elective admissions.

There is no non-authorization penalty if you do not obtain prior authorization; however, if authorization is not obtained, and it's determined when the claim is processed that services were not medically necessary, appropriate or eligible, you are liable for all of the charges.

If you disagree with the prior authorization determination decision, you may seek additional review of that claim; see "Appeals and disputes."

Eligible healthcare professionals

You need to use an eligible practitioner in order for healthcare services to be considered for coverage. (Although a practitioner may be considered eligible, not all services provided by the practitioner may be eligible; see "What's covered – medical" and "General medical exclusions.") An eligible practitioner must practice within the scope of their license or certification (as required by law) and must not be a member of your immediate family. Eligible practitioners include:

- Doctors of medicine (MD) and their supervised employees
- Doctors of chiropractic (DC) and their supervised employees
- Doctors of podiatry (DP or DPM)
- Doctors of optometry (OD)
- Doctors of osteopathy (DO)
- Optometrists
- Licensed acupuncture practitioner
- Licensed psychologists
- Licensed consulting psychologists (LCP)
- Doctors of dental surgery (DDS)
- Certified nurse midwives
- Nurse anesthetists
- Nurse practitioners
- Audiologists
- Physical therapists (PT)
- Certified speech and language pathologists
- Occupational therapists (OT)
- Master level clinical social workers (MLCSW)
- Licensed professional counselors
- Mental health professionals
- Registered dieticians

Eligible practitioners for home health care services include:

- Nurse
- Physical therapist (PT)
- Certified speech and language pathologist
- Medical technologist
- Dietitian
- Master level clinical social worker (MLCSW)
- Occupational therapist (OT)
- Home health aide

These lists may not be exhaustive; call UnitedHealthcare to verify eligibility of a provider.

Eligible facilities

You need to use an eligible facility for healthcare services to be considered for coverage. (Although a facility may be considered eligible, not all services provided by the facility may be eligible; see "What's covered – medical" and "General medical exclusions.") Eligible facilities include:

- Hospitals (must generally be licensed, under the direction of physicians, have 24-hour registered nursing services, and be privately owned, or owned or operated by state or local government)
- Skilled nursing facilities
- Residential treatment for substance-related and addictive disorders and mental health
- Hospices
- Ambulatory surgery centers
- Outpatient mental health facilities
- Outpatient substance-related and addictive disorders facilities

Ineligible facilities include:
- Retirement homes
- Nursing homes
- Spas
- Health clubs

These lists may not be exhaustive; call UnitedHealthcare to verify eligibility of a facility.

General medical exclusions

Although the plan covers most medically necessary services, some expenses are not covered. UnitedHealthcare has the discretion to determine whether a service/procedure is medically necessary; call UnitedHealthcare if you have questions.

The following services/items are not covered:

Elective, experimental or precautionary treatments and services
- Health services and supplies that **do not meet the definition of a covered service**. (See "Covered health service" in the Glossary.)
- Any treatment, service or supply that is **not medically necessary**. (See "Medically necessary" in the Glossary.)
- Any treatment, service or supply that is **not generally accepted and usual for the treatment** of an illness, in accordance with the terms of the U.S. Bank plan document and the UnitedHealthcare medical staff.
- Preventive care or any treatment, service or supply that is educational, developmental, **experimental, investigative or unproven** in nature. This includes health services that are considered experimental or investigative, performed for the purpose of research, or unproven procedures, in accordance with the terms of the U.S. Bank plan document and the UnitedHealthcare medical staff. (See "Experimental, investigational or unproven services" in the Glossary.)
- Services or supplies that are primarily and customarily used for a **non-medical purpose**, or used for environmental control or enhancement (whether or not prescribed by a physician), including, but not limited to: exercise equipment, air purifiers, air conditioners, hot tubs, whirlpools, dehumidifiers, heat/cold appliances, water purifiers, hypoallergenic mattresses, waterbeds, vehicle lifts, computers and related equipment, car seats, feeding chairs, pillows, food or weight scales and incontinence pads or pants.
- **Modifications** to home, vehicle and/or workplace, including home, work or vehicle lifts and ramps.

- **Personal comfort or convenience** items, including, but not limited to telephone, television, barber and beauty supplies and guest services.
- **Devices** used specifically as safety items or to affect performance in sports-related activities.
- **Diagnostic or monitoring equipment** purchased for home use, except as specified in "What's covered – medical."
- **Blood pressure cuff/monitoring devices, enuresis alarm, non-wearable external defibrillator, trusses, ultrasonic nebulizers**, even if prescribed by a physician.
- **Orthotic appliances** and **devices** that straighten or re-shape a body part, except as specified in "What's covered – medical."
- Custom molded **cranial orthotics** (helmets) and **cranial banding** except when used to avoid the need for surgery and/or to facilitate a successful surgical outcome.
- **Repairs** to prosthetic devices due to misuse, malicious damage or gross neglect.
- **Replacement** of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
- **Devices and computers** to assist in communication and speech, except for dedicated speech generating devices and trachea-esophageal voice devices as specified in "What's covered – medical."
- **Oral appliances** for snoring.
- Powdered and non-powdered **exoskeleton devices**.
- Services for or related to **rehabilitation** that is not expected to make measurable or sustainable improvement within a reasonable period of time, unless medically necessary and part of a specialized maintenance therapy for the patient's condition.
- Services for or related to **recreational therapy** (the prescribed use of recreational or other activities as treatment interventions to improve the functional living competence of persons with physical, mental, emotional, and/or social disadvantages); **educational therapy** (special education classes, tutoring, and other non-medical services normally provided in an educational setting); or forms of **non-medical self-care** or self-help training including, but not limited to: health club memberships, aerobic conditioning, therapeutic exercises, work hardening programs, etc.; and all related materials and products for these programs.
- Treatment, equipment, drug and/or device that the medical claims administrator determines **does not meet generally accepted standards of practice** in the medical community for cancer and/or allergy testing and/or treatment.
- Services for or related to **chelation therapy** that the medical claims administrator determines is not medically necessary.
- Services for or related to **systemic candidiasis, homeopathy and/or immunoaugmentative therapy**.
- Services for or related to **growth hormone**, except that replacement therapy is eligible for conditions that meet medical necessity criteria as determined by UnitedHealthcare prior to receiving services.
- Services for or related to **gene therapy** as a treatment for inherited or acquired disorders, except as specified in "What's covered – medical."
- Services for or related to **therapeutic acupuncture**, except for the treatment of chronic pain when treatment is provided through a comprehensive pain management program or for the prevention and treatment of nausea associated with surgery, chemotherapy or pregnancy as specified in "What's covered – medical."
- **Hospital-grade breast pumps**.

- Services for or related to **hearing aids** or devices, whether internal, external or implantable, and related fitting or adjustments, except as specified in "What's covered – medical."
- **Biofeedback**.
- **Autopsies**.
- Routine patient costs for **clinical trials** do not include the actual device, equipment or drug that is being studied, 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, or a service that is clearly inconsistent with widely accepted and established standards of care for a particular disease or condition.
- **Habilitative services** for maintenance/preventive treatment.
- Art therapy, music therapy, dance therapy, animal-assisted therapy and other forms of alternative treatment as defined by the National Center for Complementary and Integrative Health (NCCIH) 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 specified in "What's covered – medical."
- Prescribed and non-prescribed **medical supplies and disposable supplies** (such as ace bandages, gauze and dressings), except as specified in "What's covered – medical."

Service for which other primary coverage applies

- Health services eligible for payment under any **workers' compensation** or **employer's liability** law or similar law or act, or covered under any no-fault insurance policy to the extent that the no-fault policy covers services eligible under this program, or any expenses that would otherwise be the responsibility of a third party. (See "When you have other coverage.")
- The portion of eligible services and supplies paid or payable under **Medicare.** (See "When you have other coverage.")
- Charges that are eligible, paid or payable under any **medical payment, personal injury protection, automobile or other coverage** that is payable without regard to fault, including charges that are applied toward any deductible, copayment or coinsurance requirement of such a policy.
- Services recognized by the Veteran's Administration as service-connected injuries for or related to treatment of illness or injury that occurs while on **military duty.**
- Services received by your dependent if your **dependent is a U.S. Bank employee/retiree** with his/her own coverage.
- Health services needed because the patient committed or attempted to commit a **felony**, or engaged in an **illegal occupation.**
- Services that are **prohibited by law** or regulation.
- Examinations or treatment **ordered by a court** in connection with legal proceedings unless such examinations or treatment is otherwise covered under the terms of this Program.
- Services or confinements **ordered by a court or law enforcement officer** that are not medically necessary including but not limited to: custody evaluation, parenting assessment, education classes for DUI offenses, competency evaluations, adoption home status, parental competency and domestic violence programs.
- Services and supplies for which the participant is **not legally required to pay.**

Services received outside of coverage period

- Services received before Program coverage begins.

- Services received after Program coverage ends.
- Expenses incurred after the Program or plan terminates, except when the patient was confined in a hospital on the date of termination in which case, the Program would be responsible for eligible charges until the patient is discharged.

Services provided by ineligible providers

- Services, supplies, medical care or treatment given by you or by your or your spouse's immediate family, spouse, child, brother, sister, parent or grandparent.
- Services given by volunteers or persons who do not normally charge for their services.
- Services given by a pastoral counselor.
- Services that are not within the scope, licensure, or certification of a provider.

Provider administrative costs

- Charges for failure to keep scheduled visits.
- Charges for furnishing medical records or reports.
- Charges for the completion of claim forms.
- Charges in excess of eligible expenses.
- Charges for non-notification/authorization penalties.
- Charges made by a healthcare professional for email, fax and standard telephone calls.
- Services that do not involve direct patient contact, such as delivery charges and record-keeping.

Nursing and in-home care services

- Nursing services to administer home infusion therapy when the patient or caregiver can be successfully trained to administer therapy.
- Charges for or related to care that is custodial or not normally provided as preventive care or treatment of an illness.
- Charges for or related to private-duty nursing.

Services or examinations not primarily related to medical treatment

- Services for or related to functional capacity evaluations for vocational purposes and/or determination of disability or pension benefits.
- Services for or related to routine physical exams for purposes of medical research, obtaining employment or insurance, or obtaining or maintaining a license of any type, unless such physical examination would normally have been provided in the absence of the third-party request.
- Admission for diagnostic tests that can be performed on an outpatient basis unless medically necessary.
- Inpatient hospital room and board expenses that exceed the semi-private room rate, unless a private room is approved by UnitedHealthcare as medically necessary.
- Services for or related to reconstructive surgery, except as specified in "What's covered – medical."
- Cosmetic procedures. (See "Cosmetic procedures" in the Glossary.) Examples include:
  - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply for liposuction for lipedema.
  - Pharmacological regimens, nutritional procedures or treatments.
  - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).

  - Sclerotherapy treatment of veins.
  - Hair removal or replacement by any means.
  - Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
  - Treatment for spider veins.
  - Skin abrasion procedures performed as a treatment for acne.
  - Treatments for hair loss.
  - Varicose vein treatment of the lower extremities, when it is considered cosmetic.
- Membership costs for health clubs, weight loss clinics and similar programs.
- Services for or related to commercial weight loss programs, fees or dues, nutritional supplements, food, vitamins and exercise therapy, and all associated labs, physician visits, and services related to such programs.
- Nutritional counseling, except as specified in "What's covered – medical."
- Treatment for excessive sweating (hyperhidrosis).
- Intracellular micronutrient testing.
- Food of any kind, infant formula, standard milk-based formula and donor breast milk. This exclusion does not apply to specialized enteral nutrition listed in "What's covered – medical."
- Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements and electrolytes.
- Travel, transportation or living expenses – whether or not recommended by a physician — unless they are deemed eligible as part of the cancer, congenital heart disease, obesity surgery or transplant benefit.
- Services for or related to transportation other than local ambulance service to the nearest medical facility equipped to treat the illness or injury, except as specified in "What's covered – medical."

Vision correction services

- Charges for or relating to refractive eye surgery when the only goal is to minimize or eliminate dependence on glasses or contact lenses in otherwise non-diseased corneas, including laser surgery to correct myopia (nearsightedness), myopic astigmatism and/or hyperopia (farsightedness).
- Services for or related to lenses, frames, contact lenses and other fabricated optical devices or professional services for the fitting and/or supply thereof, including the treatment of refractive errors such as radial keratotomy, except as specified in "What's covered – medical."

Dental services

- Dentures and dental implants regardless of the cause or condition and any associated services and/or charges including bone grafts, except as specified in "What's covered – medical."
- Bone grafts for the sole purpose of supporting a dental implant, except as specified in "What's covered – medical."
- Preventive care diagnosis or services for or related to dental or oral care, extractions (including wisdom teeth), implants, treatment, orthodontia, surgery and any related supplies, anesthesia and facility charges, except as specified in "What's covered – medical."
- The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations, appliances.

Drugs

- 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.
- 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.
- 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 unless deemed medically necessary by UnitedHealthcare.
- 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.
- Certain new pharmaceutical products and/or new dosage forms until the date as determined by UnitedHealthcare, but no later than Dec. 31 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 in "What's covered – medical."
- Certain drugs administered by Optum Rx; see "General pharmacy exclusions."

Reproduction services

- The following infertility treatment-related services:
  – Long-term storage (greater than 12 months) of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue.
  – Cryopreservation and other forms of preservation of reproductive materials except as specified under "Infertility services."
  – 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.
- The following services related to gestational carrier or surrogate:
  – Fees for the use of a gestational carrier or surrogate.
  – Insemination or in-vitro fertilization procedures for surrogate or transfer of an embryo to gestational carrier.
  – Pregnancy services for a gestational carrier or surrogate who is not a covered person.
- Donor, gestational carrier or surrogate administration, agency fees or compensation.
- The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):
  – Purchased egg donor (i.e., clinic or egg bank) – The cost of donor eggs. Medical costs related to donor stimulation and egg retrieval. This This refers to purchasing a donor egg that has already

been retrieved and is frozen or choosing a donor who will then undergo an egg retrieval once they have been selected in the database.
  - Purchased donor sperm (i.e, clinic or sperm bank) – The cost of procurement and storage of donor sperm. This refers to purchasing donor sperm that has already been obtained and is frozen or choosing a donor from a database.
- In-vitro fertilization that is not an assisted reproductive technology (ART) for the treatment of infertility. This exclusion does not apply to in-vitro fertilization for which benefits are described under "Infertility services."
- Artificial reproductive treatments done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.
- Services for or related to reversal of voluntary sterilization.
- Infertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation).
- Infertility treatment following unsuccessful reversal of voluntary sterilization.
- Infertility treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis; vasectomy reversal/vasovasostomy or vasoepididymostomy).
- Infertility services not received from a designated provider.
- Elective fertility preservation.

Mental health, substance-related and addictive disorders and Autism Spectrum Disorders:

- 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.
- 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.
- Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, pyromania, kleptomania, gambling disorder and paraphilic disorders.
- Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
- 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.
- 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.
- Transitional living services.
- Non-medical 24-hour withdrawal management.
- 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.

Other

- Services, chemotherapy, radiation therapy (or any therapy that results in marked or complete suppression of blood producing organs), supplies, drugs and aftercare for or related to bone

marrow and peripheral stem cell support procedures, except as specified in "What's covered – medical."
- Services for or related to fetal tissue transplantation.
- Services for or related to the preservation and storage of human tissue including, but not limited to: stem cells, cord blood and any other human tissue, except as specified in "What's covered – medical."
- Services, supplies, drugs and aftercare for or related to animal organ implants.
- Services for or related to reversal of sex/gender reassignment surgery or reversal of any other surgery performed in relation to the original sex/gender reassignment surgery.
- Voice modification surgery.
- Sex Transformation operations and related services.
- Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to covered persons for self-infusion.
- Dialysis treatment performed by a non-network provider.
- Travel vaccines such as Japanese Encephalitis, Typhoid and Yellow Fever.
- Anthrax vaccine.
- Medical treatment or services identified as not covered in "What's covered – medical."
- All services, treatments, devices or supplies identifiable as being provided in conjunction with a benefit or service that is not covered. This exclusion does not apply to services that would otherwise be covered if they are to treat complications that arise from the non-covered benefit or 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.

This is not intended to be an exhaustive list. Call UnitedHealthcare/Optum Rx with any coverage questions.

What's covered – pharmacy

This section applies to the Early Retiree Medical option only. If you are enrolled in the UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs option, see the separate materials for the UnitedHealthcare Group Medicare Advantage (PPO) Plan.

Benefits are available for covered prescription drug products at either a network or non-network pharmacy and are subject to deductible, copayments and/or coinsurance or other payments that vary depending on which tier of the prescription drug list the prescription drug product is listed.

Preventive medications

Health Care Reform Preventive Drug List

Eligible preventive care drugs approved under the Affordable Care Act received with a prescription from a network pharmacy are not subject to a deductible and are paid 100% by the Program with no cost to you. Drugs received from a non-network pharmacy or without a prescription are not covered.

Prior authorization may be required by UnitedHealthcare/Optum Rx. To determine if the prescription medication is eligible and/or if prior authorization is required, call UnitedHealthcare/Optum Rx or visit uhcbenefitsusb.com. The mail order maintenance drug provision may apply.

Covered preventive drugs generally meet one or more of these criteria:

- Evidence-based recommended items or services that have a rating of "A" or "B" from the United States Preventive Services Task Force (USPSTF);
- Immunizations recommended from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC); and
- Evidence-informed preventive care and screenings for infants, children, adolescents and women provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

Core Plus Preventive Drug List
Certain medications used to treat and manage conditions such as asthma, COPD, heart disease, diabetes and more are covered when received with a prescription from a network pharmacy. These drugs are not subject to deductible; applicable coinsurance or copay will apply. Drugs received from a non-network pharmacy or without a prescription are not covered. Prior authorization may be required by UnitedHealthcare/Optum Rx. To determine if the prescription medication is eligible and/or if prior authorization is required, call UnitedHealthcare/Optum Rx or visit uhcbenefitsusb.com. The mail order maintenance drug provision may apply.

Human Immunodeficiency Virus (HIV) preventive medications
For those at high risk of HIV acquisition, certain prescription medications may be covered under the Health Care Reform Preventive Drug List when used for HIV prevention. Prior authorization may be required from UnitedHealthcare/Optum Rx. To determine if the prescription medication is eligible and/or if prior authorization is required, call UnitedHealthcare/Optum Rx or visit uhcbenefitsusb.com.

How to apply for a preventive medication exception

If the preventive medication prescribed by your physician is not included on the covered Health Care Reform Preventive Drug List available on uhcbenefitsusb.com, you may qualify for an exception. Your physician may submit an exception request to:

UnitedHealthcare
P.O. Box 30573
Salt Lake City, UT 84130-0573
Fax*: 801-994-1345

The request will need to include the following information:

- What the medication will be used for (e.g., a contraceptive drug will be used for contraceptive purposes, or gonococcal ophthalmia neonatorum prevention (GON)).
- Medical records (e.g., chart notes, lab values) showing that the medication is medically necessary for the patient, or for some preventive medications (except contraceptives), whether other alternatives have been previously attempted.

If your exception is approved, you will be able to receive your preventive medication at no cost.

If you have any questions, call UnitedHealthcare/Optum Rx.

*An expedited medication exception request may be available if the time needed to complete a standard exception request could seriously jeopardize the member's life, health or ability to regain maximum function. Urgent pharmacy fax: 801-994-1058

Non-preventive care drugs (short-term and long-term)

See the table below for non-preventive prescription drug coverage details. Coverage is determined by several factors, including:

- **Dispensing method:** Retail pharmacy or Optum home delivery. You are encouraged to use a network retail pharmacy when you need a prescription on a short-term basis only - for example, an antibiotic to treat strep throat. Use the CVS90 Saver program for long-term prescriptions; choose to receive your 90-day supply through Optum home delivery or pick up an 84- to 90-day supply at a local CVS pharmacy (where available). Use the designated Optum specialty pharmacy for all specialty medications.
- **Tier status:** See "Prescription drug list" for more information.
- **Additional requirements, limitations and exceptions** that may apply, including dosage or quantity limitations, prior authorization, etc.

Prescription drug list

All prescription drugs covered by the plan are categorized into three tiers on the prescription drug list. Under this plan, the tier status can change periodically.

Drugs typically fall into one of these categories:

- Tier-1: lowest cost drugs to you and U.S. Bank.
- Tier-2: moderate cost drugs to you and U.S. Bank. Consider a Tier-2 drug if no Tier-1 drug is available to treat your condition.
- Tier-3: highest cost drugs to you and U.S. Bank. Consider alternatives in Tier-1 or Tier-2.

Drugs can be added to or excluded from the prescription drug list at any time throughout the year. If removed, drugs may be excluded from coverage entirely or moved to a higher tier status. After your coverage is effective call UnitedHealthcare/Optum Rx or visit their site for personalized cost information. Optum Rx will automatically dispense a generic, unless your doctor indicates "DAW" or "dispense as written" on the prescription. Other substitutions may be made by the pharmacist after consulting with your doctor. Regardless of what your doctor prescribes, you are responsible for the applicable copay/coinsurance based on the drug you receive. When applicable, if a brand-name drug is dispensed and a generic is available, you will pay the applicable copay/coinsurance plus the cost difference between the brand-name and the generic. The total cost will never exceed the full cost of the brand-name drug. The amount you pay over the applicable copay/coinsurance is an ancillary charge, which will apply to your deductible, but not to your out-of-pocket maximum and is not subject to review for medical necessity.

If your doctor prescribes a medication for which a lower cost alternative is available and specifies "dispense as written" or "DAW," the pharmacist may ask your doctor whether another drug might be appropriate for you. Only if your doctor agrees, your prescription will be filled with the substituted or alternative drug and a confirmation will be sent to you and your doctor explaining the change.

Consult your doctor if you have questions or a preference as your doctor always makes the final decision on your medication.

Early Retiree Medical
The pharmacy deductible and out-of-pocket maximum under the early retiree medical option are combined with your medical deductible and out-of-pocket maximum and are non-embedded.

Pharmacy Coverage Summary – Early Retiree Medical Option*		
Covered pharmacy services	**Percentage of prescription drug charge payable by you (per covered prescription order or refill)**	**Percentage of out-of-network reimbursement rate payable by you (per covered prescription order or refill)**
Retail pharmacy (up to a 30-day supply)	**Network**	**Non-network**
Tier-1	20% coinsurance ($10 minimum**, $35 maximum)***	50% coinsurance ($50 minimum**, no maximum)***
Tier-2	30% coinsurance ($20 minimum**, $175 maximum)***	50% coinsurance ($50 minimum**, no maximum)***
Tier-3	45% coinsurance ($50 minimum**, $250 maximum)***	50% coinsurance ($50 minimum**, no maximum)***
Optum home delivery or CVS90 Saver. Use **Optum home delivery** (up to a 90-day supply) or **local CVS pharmacy** (84-90-day supply) for maintenance medications. Use the designated Optum specialty pharmacy for covered specialty drugs (30-day supply).		
Tier-1	$25 copay***	**Non-network coverage is not available**
Tier-2	30% coinsurance ($50 minimum**, $175 maximum)***	**Non-network coverage is not available**
Tier-3	45% coinsurance ($125 minimum**, $250 maximum)***	**Non-network coverage is not available**

* For the Early Retiree Medical option, all copay/coinsurance amounts above apply after your combined medical/pharmacy deductible has been satisfied, except for drugs on the "Core Plus Preventive Drug List."
**Or the full cost if less than the minimum.
***An ancillary charge may apply when a covered prescription drug product is dispensed at your request and there is another drug that is chemically equivalent.

Where applicable, sales tax will be added to copay/coinsurance amounts. Prescription drug prices can fluctuate, which may affect your medication cost. Specialty drugs are limited to a one month (up to a 30-day supply) per covered prescription and you will pay the applicable retail copay (although received via mail order).

Using Optum home delivery

New prescriptions

For non-specialty medications, ask your doctor to prescribe up to a 90-day supply of your medication, plus refills, if necessary, up to one year (or six months for most controlled substances). If you need to start your medication right away, also ask your doctor for a prescription for a 30-day supply that you can fill immediately at a retail pharmacy while your mail order is processed. You may mail your prescription and required copay/coinsurance along with a mail delivery order form to the address at the bottom of the form.

To obtain an order form and pre-addressed envelope, call UnitedHealthcare/Optum Rx or visit their site. Or, your doctor can submit your prescription on your behalf by calling, faxing or using E-prescribe.

For specialty medications, your doctor can prescribe up to a 30-day supply plus refills if necessary, up to one year (or six months for most controlled substances). Specialty medications require a prior authorization or approval before fill.

Refills
You may order **non-specialty medication refills** on or after the refill date indicated on the refill slip or on your medication container in one of three ways:

- Go to the UnitedHealthcare site. Once registered, log in and select your prescriptions available for ordering.
- Call UnitedHealthcare/Optum Rx. Be prepared to provide your member ID number from your ID card, your refill slip with the prescription number and your credit card information.
- Mail the refill and order forms provided with your medication with your copay/coinsurance to Optum Rx at the address shown on the form.

If authorized, prescriptions generally may be refilled up to one year after the date it was written, or for most controlled substances to the lesser of six months or five refills. If you request a refill before the allowed refill date, the pharmacy will hold your prescription and fill it on the date the refill is allowed.

For specialty medication refills (up to a 30-day supply), use one of the following methods:

- Go to the UnitedHealthcare site. Once registered, log in and select your prescriptions available for ordering.
- Call UnitedHealthcare/Optum Rx. Be prepared to provide your member ID number from your ID card, your refill slip with the prescription number and your credit card information.
- Mail the refill and order forms provided with your medication with your copay/coinsurance to Optum Rx or have your doctor e-Prescribe to the designated Optum specialty pharmacy.

If you apply a coupon, discount or copay card offered by a drug manufacturer or affiliate to a new or existing prescription, the amount you are required to pay for the medication will apply to your deductible and out-of-pocket maximum; however, the coupon dollar amount will not apply.

Payment
Payment is generally due at the time your prescription is filled. Options are available for installment payments for higher cost 90-day supplies. Outstanding debts could impact the timely shipment of future medication orders.

See also "Recovery of excess payments and correction of errors" for more information. Call UnitedHealthcare/Optum Rx if you have questions about your account.

Delivery

U.S. Bank provides your address to Optum Rx when you enroll in the Program; that address is used for shipments unless you change it or indicate a different address on your mail order form. You may verify or update this address by calling UnitedHealthcare/Optum Rx or updating your profile on their site.

Prescription refill orders usually are sent to you by U.S. mail in about a week; allow two to three weeks for initial orders. Overnight delivery is available for an additional charge. In addition to your medication, you may receive instructions for refills, if applicable, and information about the purpose of the medication, correct dosages and other important details. The pharmacist's judgment and dispensing restrictions, such as allowable quantities, govern certain controlled substances and other prescribed drugs. You **may not** return any dispensed drugs. Prescription orders will not be filled more than 12 months (or six months for most controlled substances) after the prescription was issued if prohibited by law or regulation.

If multiple prescriptions are submitted together, Optum Rx may need to split your order. If your order is split, a notice will be included with the part of the order that is shipped. Split orders may impact the refill dates; check the refill/renewal dates on each prescription.

Education and safety
You will receive information about critical topics like drug interactions and possible side effects with every new prescription mailed to you. You also may access other health-related information on the UnitedHealthcare site. Any written or online health information is not intended to replace the expertise and advice of your healthcare providers; it is designed to help you communicate more effectively with your doctor and, as a result, better understand your situation and choices.

Using a retail pharmacy

Most pharmacies and pharmacy chains in the United States are in the Optum Rx pharmacy network. To find a network provider, call UnitedHealthcare/Optum Rx or visit their site. When you use a network retail pharmacy and show your ID card, your claims will be filed for you (up to a 30-day supply) and you will be responsible for paying any applicable deductible, copay or coinsurance. If you do not use a network pharmacy or do not present your ID card, you may have to file your own claims and you may not receive the highest level of benefit. See “Pharmacy claims” for more information.

When a prescription drug is packaged or designed to deliver in a manner that provides more than a consecutive 30-day supply, the amount charged will reflect the number of days dispensed or days the drug will be delivered.

- As written by the provider, up to a consecutive 30-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits. If CVS90 Saver Plus applies, you may be eligible for a 90-day supply at a Preferred 90-Day Retail Partner.
- A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay the copay for each cycle supplied.

For prescription drug products at a retail network pharmacy, you are responsible for paying the lowest of:

- The applicable copay and/or coinsurance.
- The network pharmacy's usual and customary charge for the prescription drug product.
- The prescription drug charge for that prescription drug product.

Additional services – Optum Rx

Health Management Program

Health Management Program participants generally receive educational mailings and free phone access to registered pharmacists. In some programs, participants also may receive follow-up calls from Optum Rx pharmacists. Optum Rx develops these voluntary programs to support your doctor's care and may contact your doctor regarding your eligibility for, or participation in, these programs.

Additional services – Livongo by Teladoc Health

Diabetes management program

Retirees and their covered dependents enrolled in the Early Retiree Medical option administered by UnitedHealthcare and diagnosed with type 1 or type 2 diabetes are eligible for the Livongo by Teladoc Health diabetes management program. The program can help members better manage their diabetes by offering:

- Valuable tools, including the easy-to-use connected diabetes meter, unlimited test strips and other monitoring supplies.
- Self-management knowledge to help make healthy choices.
- Personalized web portal to access and share their personal health account.
- Access to Livongo by Teladoc Health's cellular, mobile and web-based diabetes management systems and technologies.
- 24/7 on call, monitoring and individualized support by Livongo by Teladoc Health's Certified Diabetes Educators (coaches) to help set and achieve goals.

To join, visit join.livongo.com/usbank or call Livongo by Teladoc Health at 800-945-4355. If you're calling, tell the Member Support Advocates that your registration code is USBANK. When you enroll, you will receive a welcome kit that includes free testing supplies (including a glucose meter and test strips). Ongoing supply refills (strips, lancets, control solution, etc.) will be mailed to you free of charge as long as you remain enrolled in the program through continued utilization of Livongo by Teladoc Health's condition management services. Diabetes medication such as insulin and pills are not covered under this program. See "Mail order maintenance drug provision" for diabetes medication coverage information.

Coverage requirements, limitations and exclusions – pharmacy

Review this section carefully for information about pharmacy coverage. Call UnitedHealthcare/Optum Rx or visit their site if you have questions about coverage and/or limits for a specific prescription drug.

Annual and lifetime maximums

Certain drugs are limited to a set lifetime or annual maximum – regardless of what your doctor prescribes. The annual or lifetime maximum may be reached by intermittent or continuous drug

therapy. Once satisfied, no further benefits will be payable. Such maximums under this Program include:

- **Infertility lifetime maximum:** You are required to enroll in the Fertility Solutions program by calling 866-774-4626 before receiving medical services or prescription drugs to treat infertility. Once you enroll, a $10,000 lifetime maximum per person applies to all eligible infertility prescription drugs. A separate $25,000 lifetime maximum per person applies to all eligible infertility services, including medical and surgical treatment; see "Infertility services" for additional information about the Fertility Solutions program.
- **Smoking cessation annual maximum:** Certain prescription and over-the-counter smoking cessation products are covered by Optum Rx for adults when prescribed by a physician. Most approved smoking cessation products are limited to a 180-day annual maximum under preventive coverage. After approximately six months of either intermittent or continuous smoking cessation drug therapy, further benefits may be paid (once the annual deductible has been satisfied).

Brand-name and generic drugs

To receive the highest level of coverage, you must use generic drugs if they are available for your condition. If a brand-name drug is dispensed when a generic is available (whether requested by you or your doctor), you will pay the applicable copay/coinsurance plus the cost difference between the brand-name and the generic. The total cost will never exceed the full cost of the brand-name drug.

The brand-name of a drug is the product name under which the drug is advertised and sold. Generic medications are sold under generic, often unfamiliar names. The U.S. Food and Drug Administration (FDA) require FDA-approved generics to have the same active ingredients and are subject to the same rigid FDA standards for quality, strength and purity as their brand-name counterparts.

If a generic alternative for a brand-name drug becomes available, the tier placement of the brand-name drug may change. Therefore, your copay and/or coinsurance may change, or you will no longer have benefits for that particular brand-name drug.

Compounded medications

Covered compounded medications are paid at the highest Tier-3 level. They are subject to applicable coinsurance minimum and maximums and must satisfy certain requirements. They must be medically necessary and not experimental or investigative, must not contain any ingredient on a list of excluded ingredients, and the cost of the compound must be determined by Optum Rx to be reasonable to be considered for coverage.

Diabetic supplies

Diabetic supplies such as syringes, test strips and lancets are covered only when received at a network retail pharmacy (first two fills only) or through Optum home delivery or the CVS90 Saver program (required after first two fills, see "Mail order maintenance drug provision"). Supplies are covered (applicable copay/coinsurance applies) once your combined pharmacy/medical deductible has been met, unless the diabetic supply is included on the "Core Plus Preventive Drug List." See "Additional services – Livongo by Teladoc Health" for information about how to receive eligible free test supplies before you meet your combined pharmacy/medical deductible as part of the Livongo by Teladoc Health diabetes management program.

General pharmacy exclusions

Exclusions from coverage listed in "General medical exclusions" also apply to this section. In addition, the exclusions below apply. If you have questions, call UnitedHealthcare/Optum Rx.

- A pharmaceutical product for which benefits are provided in "What's covered – medical." This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
- A prescription drug product prescribed for any condition, injury, sickness or mental illness arising out of or during 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.
- Any prescription drug product for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- Available over-the-counter medications that do not require a prescription by federal or state law before being dispensed, unless UnitedHealthcare has designated over-the-counter medication as eligible for coverage as if it were a prescription drug product and it is obtained with a prescription from a physician. Additionally, prescription drug products that are available in over-the-counter form or comprising components that are available in over-the-counter form or equivalent, as well as prescription drug products that UnitedHealthcare have been determined to be therapeutically equivalent to an over-the-counter drug or supplement.
- Compounded drugs that contain certain bulk chemicals or that are available as a similar commercially available prescription drug. (Compounded drugs that contain at least one ingredient that requires a prescription are assigned to Tier 3.)
- Durable medical equipment and supplies for which benefits are provided in "What's covered – medical," such as certain insulin pumps and supplies for the management and treatment of diabetes. Prescribed and non-prescribed outpatient supplies, other than covered diabetic supplies and inhaler spacers.
- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- Certain prescription drug products for tobacco cessation.
- The amount dispensed (days' supply or quantity) which exceeds the supply limit.
- The amount dispensed (days' supply or quantity) which is less than the minimum supply limit.
- Certain prescription drug products that have not been prescribed by a specialist as defined in the "Glossary."
- Certain new prescription drug products and/or new dosage forms until the date they are reviewed and placed on a tier by UnitedHealthcare's Prescription Drug List (PDL) Management Committee.
- A prescription drug product prescribed, dispensed or intended for use during an inpatient stay.
- Prescription drug products or dosage forms that are not considered a covered health service under the plan.
- Certain prescription drug products for which there are therapeutically equivalent alternatives available, unless otherwise required by law or approved by UnitedHealthcare.
- Certain prescription drug products that contain one or more active ingredients available in and therapeutically equivalent to another covered prescription drug product.

- Certain prescription drug products that contain one or more active ingredients that are modified versions of and therapeutically equivalent to another covered prescription drug product.
- Certain unit dose packaging or repackaging of prescription drug products.
- Certain prescription drug products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a prescription drug product.
- Prescription drug products used for conditions and/or at dosages determined to be experimental or investigational, or unproven, unless UnitedHealthcare has agreed to cover an experimental or investigational, or unproven treatment, as defined in the "Glossary."
- General vitamins, except for the following which require a prescription:
  – Prenatal vitamins.
  – Vitamins with fluoride.
  – Single entity vitamins.
- 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.
- A prescription drug that contains marijuana, including medical marijuana.
- Dental products, including but not limited to prescription fluoride topicals.
- A prescription drug product with an approved biosimilar or a biosimilar and therapeutically equivalent to another covered prescription drug product unless deemed medically necessary by Optum Rx.
- If a biosimilar becomes available for a reference product (a biological prescription drug product), the tier placement of the reference product may change. Therefore, your copay and/or coinsurance may change, and an ancillary charge may apply, or you will no longer have benefits for that reference product.
- Diagnostic kits and products, including associated services.
- Publicly available software applications and/or monitors that may be available with or without a prescription.
- Medications used for cosmetic or convenience purposes such as facial creams, serums, etc.

Determinations for certain prescription drugs may be made during the year and UnitedHealthcare/Optum Rx may decide at that time to reinstate benefits for a prescription drug product that was previously excluded. In addition, this is not intended to be an exhaustive list. Call UnitedHealthcare/Optum Rx with any coverage questions.

How to apply for an exception

If an excluded drug is prescribed for a specific medical condition, you may qualify for an exception. To request an exception, submit a letter to UnitedHealthcare from your physician stating the medical condition that requires the non-covered drug and the length of the projected use. The maximum time for which a letter may justify an exception is 12 months. If your exception is approved, you will be able to purchase your prescription at your local network pharmacy or by mail order by paying the applicable copay or coinsurance amount.

Mail order maintenance drug provision

After your first two fills (your initial fill for a one-month supply plus one refill) of a maintenance medication, you are generally required to use Optum home delivery for that medication. Maintenance medications are prescription drugs (including injectable and specialty injectable drugs) taken on a long-term basis (to treat allergies, diabetes, high cholesterol or high blood pressure for example) or continual basis such as oral contraceptives. If you fill your maintenance medication at a retail pharmacy after your first two fills, it will not be covered and you will need to pay the full cost of the prescription. There is no retail fill allowance for specialty medications; you must immediately fill through the designated Optum specialty pharmacy.

The two-fill limit does not reset per plan year. At times, counting two fills can be challenging if you have multiple medications or changing dosages or strengths and intermittent use or fills of a maintenance medication may impact the fill-counting logic.

Use CVS90 Saver (the Preferred 90-Day Retail Partner) for long-term prescriptions; if available in your area, you may choose to pick up your 84- to 90-day supply and pay your applicable copay/coinsurance at a local CVS pharmacy.

Medicare Part B prescription drugs

Certain drugs and supplies are covered by Medicare Part B including diabetic supplies, nebulizer solutions, certain immunosuppressant drugs used post-transplant and certain oral anti-cancer drugs. If you are enrolled in Medicare Part B coverage, the Program will coordinate with Medicare Part B. Medicare Part B will be primary and the U.S. Bank plan will be secondary. To submit prescriptions for Medicare Part B-eligible drugs to Medicare, you will need to go to a network retail pharmacy that is a licensed Medicare Part B retail pharmacy and present your red, white and blue Medicare card along with your ID card. The retail pharmacy will need to submit these claims to Medicare on your behalf as noted below:

- **Retail:** When using a retail pharmacy, you will be asked to present your red, white and blue Medicare card. The retail pharmacy will work with you to bill Medicare on your behalf. The retail pharmacy will also submit any other claims that may be eligible for additional coverage. Most independent pharmacies and national chains are licensed Medicare Part B retail pharmacies.
- **Mail:** Optum home delivery cannot coordinate payment with Medicare Part B. Therefore, if you are Medicare eligible and you submit your prescription to Optum home delivery, your prescription will not be processed.

Cost of your medication – You will be required to pay your copayment/coinsurance. If you go to a licensed Medicare Part B retail pharmacy and Medicare pays primary, you could be responsible for additional costs not paid by Medicare. To determine if your plan will pay any additional costs not paid by Medicare, ask your pharmacist to electronically submit the additional costs to Optum Rx for processing under your U.S. Bank plan. If using a retail pharmacy, you must use a network retail pharmacy that will submit your secondary claim electronically to determine if you are eligible for additional benefits. **Paper claims sent to Optum Rx will not be eligible for any additional reimbursement.**

If it is determined that the medication or product is not eligible for coverage under Medicare Part B, medications covered under the prescription drug benefit are billed under the U.S. Bank Retiree Health Care Program.

Any prescription excluded from coverage in the U.S. Bank plan is also excluded for additional benefits after the claim is processed under Medicare Part B.

Most independent pharmacies and national chain pharmacies are Medicare providers. To find a Medicare Part B–participating provider, visit the Medicare website at medicare.gov/supplier/home.asp or call Medicare at 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

This program is subject to change. If you have any questions, contact UnitedHealthcare/Optum Rx at 800-358-0114.

Quantity limits

In most cases, when you fill a prescription, you will receive the prescribed amount, up to a 30-day supply through a retail pharmacy or up to a 90-day supply through Optum home delivery (or an 84- to 90-day supply at a local CVS pharmacy where available). Certain drugs are limited, however, to a set quantity (regardless of what your doctor prescribes) based on FDA-approved dosing guidelines, medical literature or state regulations.

You may determine whether a prescription drug product has been assigned a supply limit for dispensing by calling UnitedHealthcare/Optum Rx or visiting their site.

Specialty drug provision

Specialty drugs are high cost, genetically engineered injectables, selected biologics, and selected orals designed to target and treat small patient populations with chronic, often complex diseases which require challenging regimens and a high level of expertise. Examples of such conditions include but are not limited to: Multiple Sclerosis, Rheumatoid Arthritis, cancer, hepatitis B and C, hemophilia, infertility and growth hormone deficiency. (Insulin is not considered a specialty drug.) Any prescription drug excluded from coverage also is excluded under this provision.

To be covered, you must obtain all fills of certain specialty drug prescriptions (including your first fill) through the designated Optum specialty pharmacy. You will be charged your regular retail coinsurance for each 30-day increment.

If you apply a coupon, discount or copay card through an assistance program offered by your drug's manufacturer or other affiliate to your specialty medication order, the amount you are required to pay to the specialty pharmacy for that medication will apply to your deductible and out-of-pocket maximum. While you'll still pay only the discounted amount, the plan may increase the copay to the maximum allowed through the assistance program.

UnitedHealthcare may not permit certain coupons or offers from pharmaceutical manufacturers to reduce your copay and/or coinsurance. You may access information on which coupons or offers are not permitted through www.myuhc.com or by calling the number on your ID card.

Step therapy

The step therapy program evaluates opportunities where certain first-line drugs should be tried before other, often more expensive, medications are covered. Through this program, pharmacists are informed via online messaging when a medication qualifies for step therapy. Sometimes a medication may be automatically covered if your history shows you have tried a first-line medication in the past. If not automatically covered, you or your pharmacist may call the toll-free number provided in the online messaging to initiate the review process necessary to allow coverage for your medication. In some situations, your doctor may decide to change your prescription to the less costly medication after discussing options with Optum Rx.

Call UnitedHealthcare/Optum Rx or visit their site if you have questions about coverage for a specific prescription drug product.

Prior authorization for pharmacy coverage

Before certain medications may be dispensed to you, your physician or your pharmacist must obtain prior authorization from UnitedHealthcare/Optum Rx. The prior authorization review will determine whether the drug, in accordance with UnitedHealthcare's approved guidelines:

- is considered a covered health service, as defined by the plan.
- is not an experimental, investigational or unproven service.

Where applicable, the plan may also require prior authorization to determine whether the medication was prescribed by a specialist physician.

When prior authorization is required, your retail pharmacist or a UnitedHealthcare/Optum Rx representative should inform you. You will need to ask your doctor or pharmacist to call the UnitedHealthcare/Optum Rx prior authorization line; members may not call. Prior authorization can generally be completed during the call; however, in some cases, additional information may be needed and can typically take two business days. The patient and doctor will be notified when the review process is complete. If your medication is not approved for coverage, you will receive no coverage and you will be responsible for the full cost of the drug.

Network pharmacy prior authorization

When drugs are dispensed at a network pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from UnitedHealthcare.

Non-network pharmacy prior authorization

When prescription drug products are dispensed at a non-network pharmacy, you or your Physician are responsible for obtaining prior authorization from UnitedHealthcare as required.

If you do not obtain prior authorization before the prescription drug product is dispensed, you may pay more for your medication. Additionally, you will be required to pay at the time of purchase.

You may seek reimbursement from the plan as described under “How benefits are paid.”

You may determine whether a prescription drug requires prior authorization by calling UnitedHealthcare/Optum Rx or visiting their site. Drugs requiring prior authorization are subject to UnitedHealthcare's periodic review and modification. For certain prescription drugs, you (and not your physician or pharmacist) may be required to notify UnitedHealthcare directly.

If UnitedHealthcare reviews the documentation provided and determines that the prescription drug is not a covered health service or it is an experimental, investigational or unproven service, you may not receive a reimbursement.

UnitedHealthcare may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs by calling UnitedHealthcare/Optum Rx or visiting their site.

How benefits are paid (Early Retiree Medical option only)

Medical claims

If you use a **network provider**, your provider files claims for you and the plan pays the provider directly for the covered expense. However, you are responsible for paying the provider any applicable deductibles, copayments or coinsurance directly either at the time of your visit or upon receipt of a bill.

If you use a **non-network provider**, you may need to pay that provider in full and then file a claim with UnitedHealthcare for reimbursement. Visit UnitedHealthcare's site to obtain the claim form. Claims must be submitted to UnitedHealthcare within 12 months from the date of service.

Payment of benefits

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 benefits to be paid to the 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 "Recovery of excess payments and correction of errors."

Allowed amounts due to a non-network provider for covered health services that are subject to the No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260) are paid directly to the provider.

Uncashed checks
If you do not deposit or cash a reimbursement check from the Plan within 12 months of issue, the check will be void and the amount of the check will be returned to the Plan. Returned funds will be used to offset costs and expenses incurred to administer the Plan. You may reclaim returned funds by contacting the Plan Administrator within seven years of the check's original date of issue and requesting that the reimbursement check be reissued. If you do not reclaim returned funds within seven years of the check's original date of issue, the funds will be forfeited to the Plan.

Using medical services when traveling
This section applies to the Early Retiree Medical option only. If you are enrolled in the UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs, see your plan materials.

When you receive care from a network provider within the United States, your claims automatically will be submitted to UnitedHealthcare for you, and you will not be responsible for any charges in excess of eligible expenses.

When you receive care or fill prescriptions outside the United States, you will need to submit your claims to UnitedHealthcare and/or Optum Rx yourself using a special international claim form available from UnitedHealthcare. Be sure to retrieve copies of all your medical and pharmacy records from the provider before you leave the country, ensure copies are clear and legible and ask the provider to write the bill in English if possible. The bill needs to include the patient's name, date of service, description of the services or products provided and the charge for each service or product provided. Proof of payment in the form of a cancelled check, cash receipt, charge receipt or handwritten receipt from the provider is also required.

Claims within or outside the United States will be processed based on the plan you have, the provider you use and the service received; you may call UnitedHealthcare for additional information before you travel.

Pharmacy claims

Your claims will be filed for you when:

- You use Optum home delivery; or
- You use a network retail pharmacy and show your ID card.

In both situations, you are responsible for paying any applicable deductibles, copayments or coinsurance. When you present your ID card at a network retail pharmacy, the pharmacist will confirm eligibility of coverage, collect the applicable deductible, copay or coinsurance, and file the claim with Optum Rx.

You need to pay for prescriptions in full at the time of purchase and then file claims with Optum Rx when:

- You use a network retail pharmacy, but don't show your ID card;
- You use a network retail pharmacy, but the pharmacist is unable to apply your coverage due to ineligibility or denial of prior authorization, or if you disagree with the coinsurance amount or the manner in which your prescription was filled;
- You use a non-network retail pharmacy; or
- You receive a covered compounded prescription drug (one or more prescription drugs mixed together into a final product by the pharmacist) that the pharmacy was not able to submit electronically using a Universal Claim Form.

Call UnitedHealthcare/Optum Rx or visit their site for claim forms. To be eligible for payment, claims must be received within 12 months of the date of service. Include your name, the patient's name and the member ID from your ID card, your original receipt (making a copy for your records) and your completed Optum Rx claim form to the address on the claim form.

Upon receipt, Optum Rx will process your claim at the network or non-network reimbursement rate, depending on where you had your prescription filled. All other plan criteria and provisions as noted in this SPD apply.

Eligible expenses

U.S. Bank has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a covered health service and how the eligible expenses will be determined and otherwise covered under the plan.

Eligible expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for benefits. For 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, you are responsible for paying, directly to the non-network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for eligible expenses. See "Advocacy services" for information on the assistance available to you.

- 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 deductible, coinsurance or copay 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 deductible, coinsurance or copay which is based on the recognized amount as defined in this 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 deductible, coinsurance or copay 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 deductible, coinsurance or copay 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 this SPD.

Eligible expenses are determined in accordance with UnitedHealthcare's reimbursement policy guidelines or as required by law, as described in this SPD.

Eligible expenses when using network providers
For network benefits, eligible expenses are based on the following:

- When covered health services are received from a network provider, eligible expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When covered health services are received from a non-network provider as arranged by UnitedHealthcare, including when there is no network provider who is reasonably accessible or available to provide covered health services, eligible expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed amounts in excess of your applicable deductible, coinsurance or copay to access the advocacy services described below. The plan will not pay excessive charges or amounts you are not legally obligated to pay.

Eligible expenses when using non-network providers
For non-network benefits, eligible expenses for covered health services received from a non-network provider 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 Services Health 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 UnitedHealthcare, or the amount subsequently agreed to by the non-network provider and UnitedHealthcare.
– 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 of service, you are not responsible, and a non-network physician may not bill you for amounts in excess of your applicable deductible, coinsurance or copay 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 UnitedHealthcare, or the amount subsequently agreed to by the non-network provider and UnitedHealthcare.
  – 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 deductible, coinsurance or copay 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 UnitedHealthcare, or the amount subsequently agreed to by the non-network provider and UnitedHealthcare.
  – 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 deductible, coinsurance or copay 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 as an amount negotiated by UnitedHealthcare or an amount UnitedHealthcare has determined is typically accepted by a healthcare provider for the same or similar service. The plan will not pay excessive charges. You are responsible for paying, directly to the non-network provider, the applicable deductible, coinsurance or copay. Please contact UnitedHealthcare if you are billed amounts in excess of your applicable deductible, coinsurance or copay to access the advocacy services described below. Following the conclusion of the advocacy services described below, you are responsible for paying more than the eligible expense (which includes your deductible, coinsurance and copay).

Advocacy services

The Plan has contracted with UnitedHealthcare to provide advocacy services on your behalf with respect to non-network providers that have questions about the eligible expenses and how UnitedHealthcare determined those amounts. Please call UnitedHealthcare at the number on your ID

card to access these advocacy services or if you are billed for amounts in excess of your applicable deductible, coinsurance or copay. In addition, if UnitedHealthcare or its designee reasonably concludes that the particular facts and circumstances related to a claim provide justification for reimbursement greater than that which would result from the application of the eligible expense, and UnitedHealthcare or its designee determines that it would serve the best interests of the Plan and its participants (including interests in avoiding costs and expenses of disputes over payment of claims), UnitedHealthcare or its designee may use its sole discretion to increase the eligible expense for that particular claim.

Non-network vs. network example
The following example shows how coverage is calculated under the Early Retiree Medical option when you use a non-network or network provider, assuming your annual deductible has already been satisfied. In the example, the physician's charges exceed eligible expenses.

Early Retiree Medical option			
Non-network provider		**Network provider**	
Billed charge for covered service:	$100	Billed charge for covered service:	$100
Eligible expenses:	$85	Eligible expenses:	$85
Non-network coverage (Program pays 55% of $85):	$46.75	Network coverage (Program pays 75% of $85):	$63.75
You pay $100 minus $46.75:	$53.25	You pay $85 minus $63.75	$21.25

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 by 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 visiting myuhc.com or calling the number on your ID card.

When you have other coverage

Medical and pharmacy

If you or your dependents are covered by the Early Retiree Medical option and another employer's plan, the U.S. Bank plan will integrate its payments for medical related services with those of the other group plan. The U.S. Bank plan does not integrate payments with non-group health plans or individual policies, except where required by law. In these instances, normal rules as noted below are followed for determining which plan is primary.

Integration means that benefits from both plans are coordinated. In most cases, you will not receive 100% reimbursement for medical expenses when you have coverage in two group plans. If plans are structured identically, the secondary plan might not pay any benefits. As a result, it might not be economically advantageous to be covered by two group plans.

The U.S. Bank plan will pay the difference between what it would have paid if the plan were primary, and what the primary plan paid. The following examples assume enrollment in the Early Retiree Medical option, family coverage and use of network providers.

	Example 1	Example 2
Total charge	$5,000	$5,000
What U.S. Bank would pay if it were the primary plan	$1,350 ($5,000 - $3,200 deductible = $1,8000 x 75%)	$1,350 ($5,000 - $3,200 deductible = $1,800 x 75%)
What the primary plan pays	$2,700	$1,200
What U.S. Bank program pays	$0 Difference between what the primary plan pays and what the U.S. Bank Program would have paid if it were primary	$150 Difference between what the primary plan pays and what the U.S. Bank Program would have paid if it were primary
What you pay	$2,300 ($5,000 - $2,700)	$3,650 ($5,000 - $1,200 - $150)

When the Early Retiree Medical option is the secondary plan, the medical or pharmacy bill must first be submitted to the primary plan for payment. The bill should then be sent, along with the Explanation of Benefits form from the primary plan to UnitedHealthcare or Optum Rx at the following addresses:

UnitedHealthcare
P.O. Box 740809
Atlanta, GA 30374

Optum Rx
P.O Box 650629
Dallas, TX 75265-0629

In order for integration to occur, one of the plans is determined to be primary and the other secondary. The primary plan pays first and the secondary plan pays second. The following rules apply in determining which plan is primary:

- Plans providing benefits or services under workers' compensation, personal injury protection (PIP) or no-fault insurance are always considered primary.
- Dependents of pre-65 non-Medicare-eligible retirees who are eligible for Medicare solely on the basis of having end-stage renal disease (first 30 months only), the benefit plan is primary.
- A retiree's health plan is considered primary for the retiree unless the retiree is also covered by an active employee plan. A plan that covers the retiree as a dependent (unless it is an active employee plan) is secondary.
- If a retiree or dependent is covered by an active employee plan, the active plan is considered primary for that individual.
- For dependent children covered by the plans of both parents, the "birthday rule" applies, which means the plan of the parent whose birthday falls earlier in the year pays first.
- Dependents of pre-65 non-Medicare-eligible retirees who are eligible for Medicare due to disability and who are not working, Medicare Parts A and B are primary.
- For children of legally separated or divorced parents, the plan of the parent who has child custody pays first (unless the divorce decree indicates otherwise).
- If you remarry or enter into a domestic partnership and you have custody, your plan is primary, followed by your new spouse's/domestic partner's plan, and then your former spouse's/domestic partner's plan.

In determining how to integrate benefits, UnitedHealthcare will need to receive and release medical (and possibly other) information. Unless required by law, UnitedHealthcare will not notify you or obtain your consent to exchange necessary information with other organizations to apply the integration-of-benefits rules.

When Another Person is Responsible for Your Covered Expenses

As a condition of receiving benefits under the U.S. Bank Retiree Health Care Program, you agree to assign and subrogate any and all of your rights of recovery from any other liable party. This means that if you or a covered dependent becomes ill or is injured by another party, and the U.S. Bank Retiree Health Care Program pays expenses for which another party is liable, you are required to reimburse the Program from what you receive from the legally responsible party or from any settlement or judgment. You also agree not to do anything to interfere with the Program's right to recovery. Failure to comply with these requirements will result in loss of benefits. You may be required to sign an agreement to this effect. (There are other important requirements concerning the Program's reimbursement and subrogation rights. See "Reimbursement and subrogation.")

Who's eligible

Retirees

The U.S. Bank Retiree Health Care Program is closed to new enrollments for employees that terminated/retired on or after Jan. 1, 2014. You are eligible for the Retiree Health Care Program if you were enrolled on or before this date.

Dependents

Eligible dependents

If you are enrolled in the Program and you gain a new dependent due to marriage, commencement of a domestic partnership, birth, adoption, or commencement of a legal guardianship, your newly eligible dependent may be eligible for coverage under the Program if:

- You enroll your newly eligible dependent within 60 days of the date they first become your dependent; and
- Your newly eligible dependent is and continues to be:
  - Your opposite-sex or same-sex spouse/domestic partner. A common-law spouse may be covered only if you reside in a state that recognizes common-law marriage and you meet the common-law requirements at the time you enroll the dependent in coverage. See the definition of domestic partnership in the Glossary.
  - Your or your spouse/domestic partner's children/grandchildren under age 26 who are:
    - your or your domestic partner's biological children;
    - your stepchildren;
    - your or your spouse/domestic partner's foster children;
    - children/grandchildren for whom you or your spouse/domestic partner have legal guardianship;
    - children/grandchildren legally adopted by you or your spouse/domestic partner or placed with you or your spouse/domestic partner for adoption; or
    - grandchildren who are eligible to be claimed as an exemption on your or your spouse/domestic partner's federal income tax return.
- Disabled children age 26 and older who otherwise meet the dependent children definition as long as ALL the following requirements are met:
  - the child is severely disabled by prolonged physical or mental incapacity;
  - the child became disabled prior to reaching age 26;
  - the child was covered by the Program prior to reaching age 26, or, if older than age 26, loses coverage under a parent's/guardian's plan. In the event of loss of coverage, proof of prior coverage must be provided;
  - the child is unmarried and you or your spouse/domestic partner provide more than 50% of his or her support because he or she is unable to earn a living; and
  - disabled dependent status is approved by a medical claims administrator for U.S. Bank.

If, however, one of your current dependents later gains eligibility due to a change in the eligibility requirements, you will not be able to enroll that dependent in the Program.

Ineligible dependents

Ineligible dependents include, but are not limited to:

- Dependents on active military duty in the uniformed services or armed forces of any country.
- Parents of a retiree or a retiree's spouse/domestic partner.
- A spouse from whom you are legally separated or divorced (even if the divorce decree stipulates you will continue coverage for your ex-spouse), or a domestic partner or domestic partner's dependents if your domestic partnership has ended.
- Spouses or domestic partners of your dependent adult children or grandchildren.
- Children who become disabled after age 26.

Enrolling

How to enroll

Early Retiree Medical option

To enroll a newly eligible dependent, call U.S. Bank Employee Services and speak to a representative. Coverage generally takes effect the first day of the month following the date you experience a Qualified Status Change and contact U.S. Bank Employee Services to make your election. There are two exceptions: (1) If you gain a dependent and on the first day of the month and you contact U.S. Bank Employee Services to initiate your change that same day, your dependent's coverage becomes effective on that day; and (2) If you are adding a newborn, a newly adopted child or a child placed with you for adoption, coverage for that dependent will be retroactive to the date of birth, adoption or placement for adoption.

UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs

To enroll a newly eligible dependent, call U.S. Bank Employee Services and speak to a representative. U.S. Bank Employee Services will send you an enrollment packet. You must complete an application from your claims administrator and return the application to U.S. Bank Employee Services. Coverage generally takes effect the first day of the month after your application is received and processed, or the first of the month following the date you experience a qualifying new dependent enrollment event and contact U.S. Bank Employee Services to make your election, whichever is later.

Special enrollment circumstances

Enrolling a disabled child

To have a disabled child considered for coverage, you and the child's doctor must complete an application form which you can obtain from UnitedHealthcare. UnitedHealthcare must receive the completed form no later than 30 days after the child's 26th birthday or your application will not be reviewed and your child will not be eligible for coverage. If the child is approved and the child is not considered permanently disabled, you will be asked periodically to submit proof to UnitedHealthcare that the child continues to meet eligibility requirements. Failure to provide requested information may result in loss of coverage for the dependent. If the child is approved as permanently disabled, no further action is required by you. It will be your responsibility to contact UnitedHealthcare should any changes occur.

U.S. Bank retirees/employees related to each other

If you and your spouse/domestic partner are both eligible retirees of U.S. Bank, or if your dependent is employed by U.S. Bank, you must choose a coverage level that will cover you and any eligible dependents only once. Since the plan integrates coverage for medical services and does not coordinate coverage for pharmacy, there is no benefit to being covered twice under the U.S. Bank plan.

Dependent SSN requirement

As a result of Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) which took effect Jan. 1, 2009, U.S. Bank is required to report Social Security numbers (SSNs) of covered dependents whom are U.S. citizens age three months and older. The Centers for Medicare and Medicaid Services (CMS) and health plans use this information to properly coordinate payment of benefits.

To cover your dependent(s) in a U.S. Bank medical plan, you must provide your dependent's SSN(s) during or after enrollment or take one of the following actions:

- Complete a form indicating your dependent is not a Medicare beneficiary or that you refuse to comply with this request. You must complete this form annually until the SSN is provided or the dependent is no longer covered. Obtain this form on Your Total Rewards at usbank.com/benefitsandrewards or request it by calling U.S. Bank Employee Services; or
- Notify U.S Bank if your covered dependent doesn't have an SSN because he/she is not a U.S. citizen by calling U.S. Bank Employee Services. Tax Identification number is not a valid substitute for SSN.

If your dependent is a newborn, apply for and enter his/her SSN before he/she is three months old. You may receive monthly reminders until the SSN is entered.

Situations that could affect your coverage (including becoming Medicare-eligible)

If you spend time in another part of the country

Call U.S. Bank Employee Services and make sure you have both a permanent address and an alternate address on file. As your location changes, call back and designate the appropriate address as your mailing address. This ensures you receive all retiree health care mailings.

Example: John's permanent address is Minnesota but he lives in Arizona (his alternate address) from December through April. Just before John leaves for Arizona in December, he contacts U.S. Bank Employee Services and designates his Arizona address as his preferred mailing address. Just before John returns to Minnesota in April, he contacts U.S. Bank Employee Services and designates his Minnesota address as his preferred mailing address.

If you are enrolled in the UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs, you will also need to refer to your plan materials to determine the provisions and requirements of these benefit options while traveling.

If your address changes

Call U.S. Bank Employee Services to report a change to your permanent address as soon as possible. U.S. Bank Employee Services will send you a letter confirming this change.

If you are turning age 65 or become Medicare-eligible before age 65

Your enrollment in the Early Retiree Medical option ends when you turn age 65 or become Medicare-eligible before age 65. To continue coverage under the Program, you must enroll yourself and any Medicare-eligible dependents in the UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs. You will receive information regarding enrollment in the UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs approximately 90 days prior to your 65th birthday. If you become Medicare-eligible before age 65, you must call U.S. Bank Employee Services and request enrollment materials for the UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs. Enrollment form(s) for you and any eligible dependents must be received and processed by U.S. Bank Employee Services by the deadline on your enrollment materials or you will no longer be enrolled in the Program. The effective date of coverage into the UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs will be the first of the month in which you turn age 65 (as long as your UnitedHealthcare Enrollment Request form has been processed). If

your birthday is on the first day of the month, your coverage under UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs takes effect the first of the prior month (as long as your UnitedHealthcare Enrollment Request form has been processed).

If you have non-Medicare-eligible dependents under age 65, your dependents will remain in their current Program option.

To enroll in the UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs, you and your Medicare-eligible dependents must be enrolled in Medicare Parts A and B to receive benefits. If you or your dependents do not enroll in Medicare Parts A and B, you or your dependents will not be eligible to continue coverage in the Program.

You will receive a new ID card. You will need to show your new ID card to your healthcare and pharmacy providers when receiving services.

If you are enrolled in the UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs and your dependent turns age 65 or becomes Medicare-eligible before age 65

Your covered dependent must enroll in the UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs at the time they turn age 65 or when they become Medicare-eligible if before age 65. Enrollment information will be provided to your covered dependent about 90 days prior to turning age 65. Your dependent must enroll by the deadline on the enrollment materials or your dependent will no longer be enrolled in the Program. The effective date of coverage into the UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs will be the first of the month in which your dependent turns age 65 (as long as their UnitedHealthcare Enrollment Request form has been processed). If your dependent's birthday is on the first day of the month, then their coverage under the UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs will be effective on the first of the prior month (as long as their UnitedHealthcare Enrollment Request form has been processed).

To enroll in the UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs, your Medicare-eligible dependent must be enrolled in Medicare Parts A and B. If your dependent is not enrolled in Medicare Parts A and B, they will not be eligible to continue coverage in the Program.

If you are enrolled in the Early Retiree Medical option and your dependent turns age 65 or becomes Medicare-eligible before age 65

When your dependent turns age 65 or becomes Medicare-eligible before age 65, you and your dependents will remain in the Early Retiree Medical option. Your coverage cost also will not change when a covered dependent turns age 65 or becomes Medicare-eligible before age 65. However, for that dependent, Medicare Parts A (for inpatient services) and B (for physician services, outpatient services, and supplies and equipment) will be considered the primary insurer, effective the first of the month in which the dependent turns age 65 (or the first of the prior month if the dependent's birthday is on the first of the month). The Program will assume that your dependent has enrolled in Medicare Parts A and B and UnitedHealthcare will process your dependent's claims as if your dependent had Medicare Part A and Part B, whether or not that is actually the case. If your dependent doesn't have Medicare Part A and Part B, your dependent must pay the portion that Medicare would have paid.

The Program only pays benefits when the benefit amount payable under the Program exceeds the Medicare payment.

Additionally, certain requirements, such as preadmission notification and prior authorization do not apply except for certain organ transplant services and bariatric surgery, because Medicare is primary. See "Obesity surgery" and "Transplantation services."

Integration with Medicare
Because the Program integrates coverage with Medicare Part A and Part B, your dependents must be enrolled in both programs to receive your full benefits. Here's how:

1. Medicare pays its benefit after you satisfy the applicable Medicare deductible(s).
2. The Program calculates its normal benefit based on Medicare's approved amount. If the Program's normal benefit (after your Program deductible) is greater than the Medicare payment, the Program pays the difference between the Medicare payment and the Program's normal benefit.
3. You pay the remaining amount.

When Medicare provides the same level of benefits for a service as the Program would pay (if it were primary), the Program does not pay any benefit for that service. This means that the Program may not pay any benefit for many medical services. If Medicare pays less than the Program, the Program will pay the difference. If there is no Medicare coverage for a service covered by the Program, the Program pays the benefit for that service.

Example of integration with Medicare (enrolled in Early Retiree Medical, family coverage level)*		
Total charge	$1,300	
Medicare-approved amount	$1,000	This is just an example. Actual Medicare-approved amounts are based on Medicare fee schedules.
What the Program would have paid if primary	$0	75% after $3,200 combined medical/pharmacy deductible (based on Medicare's approved amount)
What Medicare pays	$720	80% of approved amount after $100 deductible
What the Program pays	$0	Difference between what Medicare pays and what the Program would pay if it were primary.
What you pay*	$280*	$1,000 - $720 = $280*
*This example assumes the provider has accepted assignment with Medicare. If the provider does not accept assignment with Medicare, you may be billed up to the total charge. Also, the example assumes you have enrolled in Medicare Parts A and B if you are eligible to do so. If that is not the case, you also would be responsible for the amount in the "What Medicare pays" row ($720).		

Claiming health care benefits with Medicare
If your dependent is enrolled in the Early Retiree Medical option, some providers will file claims with Medicare and then UnitedHealthcare. If your dependent's provider does not, your dependent will need to file their claims with Medicare first. When Medicare has processed their claim, they will receive an Explanation of Benefits. Send this form, along with the claim form from UnitedHealthcare, to the address on the back of the ID card. Your dependent will need to contact UnitedHealthcare for claim forms. To be eligible for payment, your dependent's claims must be received by UnitedHealthcare within 12 months from the date of service.

If your domestic partnership ends

You must call U.S. Bank Employee Services to remove your former domestic partner from coverage no more than 60 days after the date you terminate your qualified domestic partnership or the date your relationship no longer satisfies the qualification requirements. Coverage for your domestic partner/domestic partner dependent(s) will end the later of the last day of the month following the date your partnership ended or the date you called to make the change. You will receive a revised Confirmation of Coverage statement that will confirm the changes made and the effect on your monthly premium.

If you marry your domestic partner

If you marry your opposite-sex or same sex domestic partner, you must contact U.S. Bank Employee Services no later than 60 days after the date of your marriage. In this event, you would be eligible to enroll your spouse and/or your spouse's eligible dependents in coverage. Even if your spouse was enrolled in coverage prior to your marriage, you must contact U.S. Bank Employee Services to report that you are married so that your retiree health care company paid subsidy is no longer reported as imputed income. This change will typically take place the first of the month following the date you notify U.S. Bank Employee Services.

Qualified Medical Child Support Orders

A Qualified Medical Child Support Order (QMCSO) is any judgment, decree or order (including approval of a settlement agreement) for one parent to provide a child or children with healthcare coverage. If U.S. Bank receives a QMCSO for your child or children, we will contact you concerning the procedures for such an order. You also may request a free copy of the QMCSO procedures from U.S. Bank Employee Services any time.

Generally, coverage for the child who is the subject of the QMCSO will become effective on the date specified in the QMCSO or at a later date as specified in the QMCSO procedures of U.S. Bank. In addition, U.S. Bank will increase your deduction or bill you for appropriate charges beginning on the date the QMCSO becomes effective. If the request for coverage is not made within 31 days of the date of the QMCSO, coverage for the child will be subject to all of the terms of the Retiree Health Care Program, as applicable.

For more information on QMCSOs and National Medical Support Notices (NMSNs) visit the Qualified Order website at QOCenter.com.

If you return to work after retirement

You may either continue your coverage under the U.S. Bank Retiree Health Care Program or enroll in an active employee medical plan. If you remain enrolled in the Retiree Health Care Program, any remaining accumulated retiree health care credits will continue to earn interest during your period of re-employment. If you enroll in an active employee medical plan, you will not be able to re-enroll in the Retiree Health Care Program at any time in the future and will forfeit any remaining health care credit balance. These rules are also subject to the generally reserved right of U.S. Bank to amend or terminate coverage under the Program (see "Amendment or termination of the plans"). Some general rules are stated below.

If you die

Under the current terms of the Program, if you die and your family is covered by the U.S. Bank Retiree Health Care Program, your spouse/domestic partner can continue retiree health care coverage as long as the Program continues to be available and subject to any changes made to the Program. In addition, your children can stay covered for as long as they are eligible, and your spouse/domestic partner continues under the Program. However, your spouse/domestic partner may not add any dependents to the Program at any time. If after your death, your spouse/domestic partner also dies, coverage for your covered dependent children will end, subject under certain circumstances to rights to COBRA.

When coverage ends

Your coverage under the Program will end when one of the following events first occurs.

For you:

- You die;
- You no longer satisfy the eligibility requirements for participation;
- You fail to pay any required premiums in full by the required due date;
- You request that coverage be terminated;
- You are on active duty military leave deployment for more than six weeks or other military training leave lasting more than 90 days (see "USERRA"); or
- The Program is discontinued or amended so that you lose eligibility.

In addition to the events listed above, coverage for your dependents will end on the last day of the month when one of the following events first occurs:

- Divorce, legal separation or termination of domestic partnership (if you terminate your domestic partnership, coverage for your partner and any covered dependent(s) of your partner will end);
- The dependent child reaches his/her 26th birthday;
- The dependent no longer satisfying the dependent criteria for participation in a plan or Program;
- For dependent children only, the death of both you (the retiree) and your spouse;
- For dependent children only, you die and your spouse/domestic partner cancels coverage;
- A decision by you to terminate coverage; or
- You fail to provide requested documentation that proves your dependent's eligibility for coverage or the documentation you provide does not verify your dependent's eligibility for coverage.

Early Retiree Medical option – If one of the events listed earlier occurs, coverage will end the last day of the month in which the event occurs unless noted otherwise.

UnitedHealthcare Group Medicare Advantage (PPO) with Prescription Drugs – Coverage will be cancelled as soon as administratively feasible.

If you commit an act, practice or omission that constituted fraud, or an intentional misrepresentation of a material fact, U.S. Bank reserves the right to terminate coverage retroactively with proper notice.

If you don't notify U.S. Bank of dependent ineligibility

If you do not call U.S. Bank Employee Services within 60 days of the date your dependent became ineligible, coverage will be cancelled retroactively from the date you do contact U.S. Bank Employee

Services to the end of the month in which your dependent became ineligible. In this event, if your coverage level changed, premiums for coverage will be refunded for the period between the date coverage for the dependent was cancelled and the date your new premiums became effective. You will be responsible for any claims incurred after the coverage end date. Your dependent will be eligible for COBRA coverage. (If your dependent is enrolled in the UnitedHealthcare Group Medicare Advantage (PPO) with Prescription Drugs their coverage will be canceled as soon as administratively feasible).

USERRA

If you lose coverage for this benefit because of duty in the uniformed services, you and your covered dependents will be entitled to elect certain continuing coverage. This extended coverage will last no more than 24 months and cannot be extended regardless of the occurrence of any other subsequent event. This complies with the benefit provisions of the Uniformed Services Employment and Reemployment Rights Act (USERRA). The uniformed services are:

- 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 Act; and
- Any other category of persons designated by the President of the United States in time of war or emergency.

Coverage cancellation

You can cancel coverage for yourself and/or your dependents at any time by calling U.S. Bank Employee Services. If you cancel or lose retiree health care coverage under the Program for any reason (including non-payment of premiums), you will not be able to re-enroll in the Program. If you cancel or lose retiree health care coverage, any covered dependents will also lose coverage, subject under certain circumstances and rights to COBRA coverage. Similarly, if you cancel coverage for an eligible dependent for any reason, that dependent will not be able to re-enroll in the Program.

Early Retiree Medical option – Coverage will end first of the month following the date that you contact U.S. Bank Employee Services to cancel coverage, or if you call on the first of the month, your coverage will be canceled that day.

UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs – Coverage will end the first of the month following the date that U.S. Bank Employee Services receives a written request to cancel coverage for you and/or your dependents. This request must be signed and dated by each member that wants to cancel coverage under the UnitedHealthcare Group Medicare Advantage (PPO) Plan.

Continuing dependent coverage under COBRA

In some cases, your spouse and/or your dependent children may have the option of continuing coverage when coverage would otherwise end. Except for domestic partners and domestic partner's dependents, this continuation right is provided in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). For domestic partners and domestic partner's dependents, COBRA-like continuation coverage is offered.

How COBRA works

Your spouse, domestic partner and dependents can continue only the coverage they were enrolled in prior to becoming eligible for COBRA. However, if you were enrolled in an option that has a service area and your dependent no longer reside in that service area, another option will be offered based on their new address.

Although you can decrease coverage when enrolling in COBRA, you are not allowed to increase coverage unless you have newly eligible dependents. You must call U.S. Bank Employee Services and complete the enrollment process within 60 days of the qualifying event (birth, marriage, etc.). Your COBRA information will tell you how to add new dependents.

Your benefit changes will be effective on the first day of the month following the date you make your election, with two exceptions: if you make your election on the first day of the month, your coverage becomes effective on that day; if you are enrolling a newborn, newly adopted child or child placed with you for adoption, coverage will be effective retroactive to the date of the event. (See "Who's eligible" for a description of eligible dependents.)

Qualifying events and length of coverage

Coverage can be continued for up to a total of 36 months. Your eligible dependents can choose to continue coverage if it would otherwise end because of any of these events:

- For dependent children if you die and your spouse is not covered by the Program;
- Your divorce or legal separation;
- Termination of domestic partnership (in this event, dependents of your domestic partner also would lose coverage and be eligible to continue coverage);
- Change in a dependent's status (e.g., a dependent reaches age 26, or is no longer considered an eligible dependent under the Program); or
- The commencement by U.S. Bank of a bankruptcy, under Title 11, United States Code.

Cost of continued coverage

During the COBRA continuation period your dependents will pay the full cost of coverage plus an additional 2% for administrative expenses each month. U.S. Bank reserves the right to change premiums at any time and as permitted by law.

Your dependents have 45 days from the date continuation coverage is elected to make the first premium payment. Subsequent premium payments are due in full by the first day of each month. Information regarding payment deadlines will be included with the information you receive regarding continuation. If the first payment is not made in full within the 45-day period (checks returned for insufficient funds do not qualify as payment and special rules for partial payments may apply), no COBRA coverage will be provided. If any subsequent payment is not made in full within 30 days of the first day of the month (checks returned for insufficient funds do not qualify as payment and special rules for partial payments may apply), coverage will be cancelled retroactive to the end of the last month for which full payment was made. Your dependents will not receive a reminder notice. Once coverage is cancelled, it will not be reinstated.

How to enroll

If your dependents become eligible for continued coverage because of your death, they will receive notification of their COBRA options to your home address within 44 days from the date their coverage ends. The notice will indicate the cost for continued coverage. However, your dependents may enroll prior to receiving the materials. They may call U.S. Bank Employee Services to make their COBRA elections.

If continuation is a result of divorce, legal separation, termination of domestic partnership or change in dependent status, your dependents must call U.S. Bank Employee Services within 60 days from the date of the event to qualify for continued coverage. The COBRA Administrator will then send your dependents information about electing continued coverage. If your dependents do not call U.S. Bank Employee Services within this time frame, their retiree health care coverage will be terminated retroactive to the date of ineligibility (if you are enrolled in the UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs , retiree health care coverage will be terminated as soon as administratively feasible). Any COBRA coverage your dependent elects will be effective the first of the month following the date coverage ends.

For coverage to continue, U.S. Bank Employee Services must receive completed election forms within 65 days after whichever is later:

- The date the coverage would otherwise end; or
- The date your dependents are provided notice of their right to continue coverage.

Although your dependents have 65 days in which to make their decision, COBRA coverage is not reinstated back to the date the Retiree Health Care Program coverage ended until your dependents return the election forms and make full payment for coverage. Once their election form and payment are received, reactivation of coverage generally takes about three weeks. Until coverage is reactivated, your dependents must pay for services. When their coverage is reactivated, they can then submit the bills for reimbursement.

When continued coverage ends

Continued coverage will end before the 36-month limit and will not be reinstated if:

- Your dependent(s) fail to pay the required premiums in full by the specified deadlines. It is your dependent's responsibility to make payment in full by the required due date each month; they will not receive a reminder notice. Checks returned for insufficient funds do not qualify as payment; special rules for partial payment may apply.
- Your dependent(s) become covered under another group plan after the date COBRA is elected unless the plan includes pre-existing condition limitations that apply to your dependent(s).
- U.S. Bank no longer offers group medical coverage to its retirees.
- Your dependent(s) become entitled to Medicare benefits after the date COBRA is elected.
- It is determined that your dependent does not meet eligibility requirements or you fail to provide documentation verifying your dependent’s eligibility.

Continued coverage will terminate for your dependent(s) at the end of the month in which your dependent is deemed ineligible for continued coverage or as of the day on which U.S. Bank is notified that your dependent has gained other medical coverage.

Cancellation due to nonpayment of premiums will be effective the first day following the period of coverage for which your dependent(s) have paid premiums by the specified deadlines. If your dependent's medical coverage is cancelled due to nonpayment of premiums, coverage will also be cancelled for any other COBRA plans they have elected.

If coverage for your dependent(s) is cancelled based on ineligibility or due to nonpayment of premiums, any additional premiums your dependent may have paid for coverage under the Program will be refunded to your dependent, and they will be responsible for any claims incurred after the date their coverage was cancelled.

Appeals and disputes

This section describes the claim-and-review procedures for the Early Retiree Medical option.

If you are enrolled in the UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs, you will receive separate materials from that Claims Administrator explaining the claim-and-review procedures for your plan. You must follow the claim-and-review procedures contained in the separate materials to ensure the highest level of benefits. The UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs is fully insured. The insurer has the sole authority, discretion and responsibility to interpret and construe the terms of the benefit plan it insures, and determine all factual and legal questions under such benefit plan, including but not limited to eligibility to participate, the entitlement of benefits and the amount of benefits to be paid, if any. U.S. Bank has no authority to make determinations with respect to the UnitedHealthcare Group Medicare Advantage (PPO) Plan with Prescription Drugs. Your only source of recovery is from the applicable insurer.

These claims and appeals procedures are effective Jan. 1, 2024. These procedures include provisions provided by federal health reform law, regulation and sub-regulatory guidance. Some of the provisions may be eliminated or changed in subsequent guidance, and to the extent this occurs, the Program will be administered in accordance with such eliminations or changes. The Program reserves the right to delay compliance to the latest date permitted under current or future regulations. U.S. Bank has delegated authority and discretion to decide internal claims and appeals relating to ERISA claims for benefits to the claims administrators responsible for the benefit in question.

Eligibility and enrollment claims for all options

All claims or disputes regarding eligibility and enrollment, must be submitted in writing to:

U.S. Bank Benefit Claim Subcommittee
EP-MN-R2BN
4000 W. Broadway
Robbinsdale, MN 55422-2299
Fax: 833-691-7958

Within 60 days after your claim is received, you will receive a written notice of the decision. If your claim is denied, in whole or in part, the Claim Reviewer will further notify you of your right to additional review of your denied claim.

If your request for review is denied in whole or in part and you still disagree with the decision, within 60 days of the date you receive written notice, you must deliver to the U.S. Bank Benefit Claim Subcommittee a written request for a final claim determination at the above address. Your request for a final claim determination should include any documentation supporting your claim.

If your claim dispute relates to dependents removed from coverage due to failure to provide documentation verifying their eligibility, include the documentation that will prove the dependent is eligible along with your letter. If your request is approved, and your dependent was removed from coverage less than 60 days prior to the submission of your appeal, coverage will be reinstated without lapse. If your request is approved, and your dependent was removed from coverage more than 60 days prior to the submission of your appeal, coverage will be reinstated retroactively to the first day of the month preceding the date you submitted your appeal. You will be responsible for any claims incurred between the time coverage ended and the date it was reinstated.

Release of medical records and medical reviews

Generally, your medical or pharmacy information may be used without obtaining your authorization or consent for purposes of claims payment and other medical or pharmacy operations required by the Program. However, in some circumstances, an authorization for the release of medical records may be required and you may be asked to sign an authorization permitting the disclosure of your medical records for this purpose.

Internal ERISA claims procedures

Initial claim determination

Under ERISA's claims procedures, there are three types of claims:

- Post-service claims: any claim for payment filed after medical services or supplies have been received and any other claim that is neither a pre-service nor an urgent claim.
- Pre-service claims: any claim for a benefit that, under the terms of the Program, recommends notification or approval prior to receiving medical treatment or supplies (e.g., prior authorization or preadmission notification).
- Urgent claims: a pre-service claim (as defined above), where, in the opinion of the claimant's healthcare provider, a delay in providing medical treatment or supplies might jeopardize the life or health of the claimant, or jeopardize the ability to regain maximum function or subject the claimant to severe pain that cannot be managed adequately without the care or treatment that is the subject of the claim.

The time period for deciding each type of claim and notifying you of such decision differs based upon the nature of claim. The chart in this section provides the time periods for notifying you of the initial claim decision, any possible extensions and the time periods for you to provide additional information, if needed.

Within the timeframes indicated in the chart below, you will receive either:

- Written notice of the decision; or
- One of the following based on the type of claim:
  – for post-service claims, notice describing the need for additional time to reach a decision due to reasons beyond the control of the claims administrator;

– for pre-service claims, notice that your claim was filed incorrectly and information about how to correctly file a claim or notice describing the need for additional time to reach a decision due to reasons beyond the control of the claims administrator; or
– for urgent claims, notice that the claim is incomplete.

If additional time is needed, the notice will describe the reason(s) for the extension and the date by which you can expect a decision.

If the claim is incomplete or additional information is needed, the notice will specifically describe the additional information needed to complete the claim. You will then have the time period indicated in the fourth column of the chart to provide the specified additional information. The time between the date the notice is sent and the date the requested information is received from you shall not count against the time period for deciding your claim.

If you fail to follow the procedures for submitting a pre-service claim, you will be notified of the correct process for submitting a pre-service claim within five days after the incorrect claim is received. This notice may be provided orally, unless you request written notification.

Type of claim	Deadline for notifying claimant of initial claim determination	Extensions to deadline for notifying claimant of initial claim determination	Time period, if any, for claimant to provide additional information
Post-service claims	**30 days** after receipt of the initial claim	**15-day** extension available	**60 days** after claimant receives notice of need for additional information
Pre-service claims	**15 days** after receipt of the initial claim **Incorrectly filed claims: five days** from the date the incorrect claim was received by a person regularly responsible for handling claims	**15-day** extension available	**60 days** after claimant receives notice of need for additional information
Urgent claims	No later than **72 hours** after receipt of the initial claim, taking into account the medical urgency	**Complete claims: n/a** **Incomplete claims: 48 hours** after earlier of: • the date claimant provides requested information; or • the end of 48-hour period for claimant to provide requested information	**48 hours** from the time claimant receives notice of an incomplete claim

For pre-service and urgent claims only, you will receive notice for approved claims as well as denied claims.

If your claim is denied, in whole or in part, you will receive a written notice, including:

- Information about your claim and the reason(s) for the denial;
- The plan or Program provisions on which the denial is based;
- A description of additional material (if any) needed to perfect the claim;
- An explanation of your right to request a review;
- A statement of your right to file a civil action under section 502(a) of ERISA if your claim is denied upon a request for review;
- A statement indicating whether an internal rule, guideline, protocol or other similar criterion was relied on in deciding your claim and information explaining your right to request such information, free of charge;
- If an adverse benefit determination is based on medical necessity or experimental treatment or a similar exclusion or limitation, an explanation of the scientific or clinical judgment for the determination applied to your medical circumstances;
- For urgent claims only, a description of the expedited review process applicable to such claims;
- Description of the Program's standard, if any, used in denying the claim (e.g., if a medical necessity standard is used to deny the claim, the notice must describe the medical necessity standard);
- Description of available internal appeals and external review processes; and
- Disclosure of availability of and contact information for any applicable office or health insurance consumer assistance or ombudsman, if any, established by the Department of Health and Human Services to assist in internal claims, appeals and external review process.

If a claim for benefits is denied in whole or in part, you may call the claims administrator at the number on your ID card before requesting a formal appeal. If the claims administrator cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below. Calling the claims administrator will not start the formal appeal process.

Request for review of adverse benefit determinations

If your initial claim is denied in whole or in part and you disagree with the decision, you may request review of the decision or adverse benefit determination. An adverse benefit determination is defined as a) a denial, reduction, or termination of benefits, or b) a failure to provide or make payment (in whole or in part) for a benefit. (A rescission of coverage is also an adverse benefit determination; see "Special rules for claims related to rescission" for information on how to appeal a rescission.) Within 180 days of the date you receive an adverse benefit determination with which you disagree, submit a request for review to your claims administrator. With the exception of urgent claims which may also be submitted orally, submit all requests for review in writing.

Your request for review may (but is not required to) include issues, comments, documents, records and other information relating to your claim that you want considered in reviewing your claim. You may request reasonable access to and copies of all documents, records and other information relevant to your adverse benefit determination without charge.

In reviewing your claim, your claims administrator will ensure your claim is reviewed by individuals who were not involved in the initial adverse benefit determination. The claims administrator will not defer to the initial claim reviewer's decision and will look at your claim anew. If your adverse benefit determination was based upon medical judgment, a healthcare professional with the appropriate training and experience in the field of medicine involved in the medical judgment will be consulted during the review of your claim. The healthcare professional will not have been involved in the initial adverse benefit determination and will not be a subordinate of any person previously consulted. You may request information regarding the identity of any healthcare professional whose advice was obtained during the review of your claim.

If the claims administrator considers, relies on or generates new or additional evidence in connection with its review of your claim, you'll be provided the new or additional evidence free of charge as soon as possible and with enough time before a final determination is required to be provided to you (see the chart under "Determination upon request for review" below) so that you will have an opportunity to respond. If the claims administrator relies on a new or additional rationale in denying your claim on review, you'll be provided with the new or additional rationale as soon as possible and with enough time before a final determination is required to be provided to you (see the chart under "Determination upon request for review" below) so that you will have an opportunity to respond. You also may review the claim file and present evidence and testimony.

Determination upon request for review
The time period for deciding a request for review of an adverse benefit determination and notifying you of such a decision depends upon the type of claim (e.g., pre-service claims vs. post-service claims). The chart below provides the time periods in which your claims administrator will notify you of its decision on your request for review for each type of claim. These time periods will not be extended for any reason.

Type of claim	Deadline for notifying claimant of request for review determination
Post-service claims	**60 days** after receipt of the request for review
Pre-service claims	**30 days** after receipt of the request for review
Urgent claims	No later than **72 hours** after receipt of request for review, taking into account the medical urgency

For pre-service and urgent claims only, you will receive notice for approved claims as well as denied claims.

If upon review, the denial of your claim is upheld in whole or in part, you'll receive a notice from your claims administrator (by phone, fax or other similarly prompt method for urgent claims) including:

- Information about your claim and the reason(s) the denial was upheld;
- The plan or Program provisions on which the denial is based;
- An explanation of your right to request reasonable access to and copies of the relevant documents, records, and information used in the claims process without charge;
- A description of any voluntary appeal procedures offered by the Program (although currently the Program does not have such voluntary appeal procedures);
- A statement of your right to file a civil action under section 502(a) of ERISA if your claim is denied upon a request for review;

- A statement indicating whether an internal rule, guideline, protocol or other similar criterion was relied on in deciding your claim and information explaining your right to request such information, free of charge;
- If an adverse benefit determination is based on medical necessity or experimental treatment or a similar exclusion or limitation, an explanation of the scientific or clinical judgment for the determination applied to your medical circumstances;
- Description of the Program's standard, if any, used in denying the claim (e.g., if a medical necessity standard is used to deny the claim, the notice must describe the medical necessity standard);
- Discussion of the decision;
- Description of any available external review processes; and
- Disclosure of availability of and contact information for any applicable office or health insurance consumer assistance or ombudsman, if any, established by the Department of Health and Human Services to assist in internal claims, appeals and external review process.

Filing a second appeal
If you are not satisfied with the first review of an adverse benefit determination decision, you have the right to request a second request for review of an adverse benefit determination. This additional request must be submitted within 60 days from receipt of the first adverse benefit determination decision.

Note: Upon written request and free of charge, you may examine your claim and/or appeal file(s). You may also submit evidence, opinions and comments as part of the internal claims review process. The claims administrator will review all claims in accordance with the rules established by the U.S. Department of Labor. You 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: (1) any new or additional evidence considered, relied upon or generated by the plan in connection with the claim; and, (2) a reasonable opportunity for you to respond to such new evidence or rationale.

Special rules for concurrent claims (medical)
Concurrent claims are claims that relate to a previously approved period of time or number of treatments for an ongoing course of medical treatment.

If you request an extension of a previously approved period of time or number of treatments and your claim involves urgent care, the claims administrator will decide your claim and notify you of its decision within 24 hours after receipt of your request; provided your claim is filed at least 24 hours prior to the end of the approved time period or number of treatments. If you did not file the claim at least 24 hours prior to the end of the approved treatment, the claim will be treated as and decided within the timeframes for an urgent claim as described under "Initial claim determination." If your claim does not involve urgent care, then the time periods for deciding pre-service claims and post-service claims, as applicable, will govern.

If there is a reduction in or termination of the ongoing course of treatment for which you have received prior approval (for reasons other than amendment or termination of the Program), the claims administrator will notify you. This reduction or termination of an ongoing course of treatment will be considered an adverse benefit determination. You will receive notice in advance of the date the

reduction or termination will occur so that you have a sufficient opportunity to appeal the decision before the reduction or termination occurs. If you appeal the reduction or termination of your ongoing course of treatment, the reduction or termination won't occur before a final decision is made on your appeal. If you disagree with the reduction or termination, follow the procedures described previously for requesting a review of an adverse benefit determination. The time periods that will apply to your request will depend on the nature of your concurrent claim (e.g., urgent vs. pre-service vs. post-service).

Special rules for claims related to rescission

A rescission is a discontinuation of coverage with retroactive effect. Coverage may be rescinded because the individual or the person seeking coverage on behalf of the individual commits fraud or makes an intentional misrepresentation of material fact, as prohibited by the terms of the Program. However, some retroactive cancellations of coverage are not rescissions. Rescissions do not include retroactive cancellations of coverage for failure to pay required premiums or contributions toward the cost of coverage on time. A prospective cancellation of coverage isn't a rescission. If your coverage is going to be rescinded, you'll receive written notice 30 days before the coverage will be cancelled. A rescission will be considered an adverse benefit determination. You may then appeal the rescission as described under "Request for review of adverse benefit determinations." Internal request for review of rescission denials should be submitted to and will be decided by the U.S. Bank Benefit Claim Subcommittee. For purposes of rescissions, the U.S. Bank Benefit Claim Subcommittee will be the claims administrator.

External appeal process

If upon review, your claim still is denied and you disagree with the claims administrator's decision, you may submit your claim to the external appeal process described below if your claim denial involves either medical judgment, a rescission or a claim subject to the No Surprises Act. Other types of claim denials are not eligible for external appeal. This step is not mandatory.

In most circumstances, before you may submit your claim to the external appeal process, first you must follow the claims procedures outlined above by filing an initial claim and a request for review of an adverse benefit determination with your claims administrator. However, in certain circumstances described below, you may receive an expedited external review. In this case, you may not have to exhaust the internal claims process before filing a request for external review.

Within four months of the date you receive notice that, upon review, your claim continues to be denied, you may submit your claim to the external process by writing to your claims administrator.

Your written external appeal may (but is not required to) include issues, comments, documents, records and other information relating to your claim that you want considered in reviewing your claim.

Under the following circumstances, you may request an expedited external review:

- If you have received an initial claim determination that denied your claim, you may request expedited external review if: (1) you filed a request for an urgent appeal, AND (2) the time for completing the internal review process would seriously jeopardize life, health or ability to regain maximum function.

- If you appealed your initial claim denial and received a final internal claim denial and: (1) the time for completing the external review process would seriously jeopardize life, health or ability to regain maximum function; OR (2) the denial of the internal appeal concerned the admission, availability of care, continued stay or healthcare item or service for which you received emergency services, but you haven't been discharged from a facility.

Preliminary review of standard (not-expedited) external claims
Within five days of receipt of the external review request, your claims administrator will complete a preliminary review of your request to determine if your claim is initially eligible for external review. Your claim is initially eligible for external review if:

- You are or were covered under the Program when the item or service was requested or provided;
- The claim or appeal denial does not relate to your failure to meet the Program's eligibility requirements;
- You have exhausted the internal appeal process (unless you are not required to exhaust the internal claims procedures); and
- You have provided all information and forms required to process external review.

Within one business day after completion of the preliminary review, your claims administrator will notify you in writing regarding whether your claim is initially eligible for external review. If your request was not complete, the notice will describe information or materials needed to complete your request. You will have until the end of the four-month period you had to file a request for an external review or 48 hours (whichever is later) to complete your request. If your request is complete but not initially eligible for external review, the notice will include the reasons your request was ineligible and contact information for the Employee Benefits Security Administration.

External review process
If your claims administrator determines your claim is initially eligible for external review, your claim will be assigned to an independent review organization. This organization will notify you that your claim is initially eligible for external review and that the review process is beginning. The notice will also inform you that you have 10 business days following receipt of the notice to provide additional information to the independent review organization for it to consider. However, if the independent review organization determines that your claim does not involve either medical judgment or a rescission, it will notify you that the claim is not eligible for external review.

If your claim is eligible, the independent review organization will not defer to the decisions made during the internal review process and will look at your claim anew. The independent review organization will consider all the information and documents that it receives in a timely manner when making its decision.

The independent review organization and/or your claims administrator will provide written notice of the final external review decision within 45 days after it receives the request for external review.

If the independent review organization reverses the claims administrator's denial of your claim, the decision will be binding on the Program, and the Program must immediately provide coverage or payment, regardless of whether it intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review process
Generally, the same rules that apply to standard external review apply to expedited external review, except the timeframe for decisions and notifications is shorter.

Expedited Preliminary Review – Your claims administrator immediately will conduct a preliminary review to determine if your claim is initially eligible for external review. After the preliminary review is completed, your claims administrator will notify you immediately of its determination. If your request was not complete, the notice will describe information or materials needed to complete the request. You'll have until the end of the four-month period you had to file a request for an external review or 48 hours (whichever is later) to complete your request.

Expedited External Review – If your claim is initially eligible for expedited external review, your claim will be assigned to an independent review organization. This organization will provide you its final decision as expeditiously as your medical condition or circumstances require, but in no event will the notification be provided later than 72 hours after the independent review organization receives the request for expedited external review. If the notice of the decision is not provided in writing, then the independent review organization must provide you with written confirmation of the decision within 48 hours after the notice of decision was first provided to you by other means.

The period during which your external appeal is brought and decided will not count against the time period permitted for you to bring a lawsuit (e.g., any applicable statute of limitations will be tolled). Submitting your claim to the external appeal process is not a prerequisite and does not prevent you from filing a civil action under section 502(a) of ERISA once the claim-and-review procedure has been completed.

Failure to strictly adhere to internal claims and appeals process
If the claims administrator fails to strictly adhere to the internal ERISA claims procedures described above and claims and appeals guidance issued by the Department of Labor, you will be deemed to have exhausted the internal claims and appeals process and you may initiate an external review or bring suit under section 502 of ERISA. However, this strict adherence rule does not apply if the violation is:

- Very minor,
- Non-prejudicial,
- Attributable to a good cause or matters beyond the Program's control,
- Made in the context of an ongoing good faith exchange of information, and
- Not reflective of a pattern or practice of noncompliance.

If the claims procedures have not been strictly adhered to, you have the right to request a written explanation of the violation from the claims administrator. Within 10 days after receipt of your request, the claims administrator will provide you an explanation of the basis, if any, for asserting the violation should not cause the internal claims and appeals process to be deemed to be exhausted. If an external reviewer or court rejects your request for immediate review, you'll be able to resubmit your claim and pursue the internal claims process.

General rules for internal and external claims

- Your initial claim, any request for review of an adverse benefit determination, and any request for external appeal must be made in writing, except for requests for review of adverse benefit determinations relating to urgent claims, which also may be made orally.
- You must follow the claim-and-review procedure contained in this SPD carefully and completely and you must file your claim before any applicable deadlines. If you do not do so, you may give up important legal rights.
- Your casual inquiries and questions will not be treated as claims or requests for a review or submissions to the external appeal process.
- You may have a lawyer or other representative help you with your claim at your own expense (the claims administrator or U.S. Bank may require written authorization to verify that an individual has been authorized to act on your behalf, except that for urgent claims a healthcare professional with knowledge of the claimant's medical condition will be permitted to act as an authorized representative).
- You are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to any adverse benefit determination. You also will be allowed to review the claim file and present evidence and testimony as part of the internal claims and appeal process.
- You must comply with any additional requirements for filing a claim (e.g., using a specific claim form) imposed by the claims administrator.

Exhaustion of administrative remedies

The exhaustion of the claim-and-review procedure (with the exception of the external claim review process) is mandatory for resolving every claim and dispute arising under this Program prior to initiating legal action (except if the internal claim and appeal process is deemed exhausted under the rules in "Failure to strictly adhere to internal claims and appeals process"). If any legal action brought after you have exhausted the administrative remedies, all determinations made by the claims administrator, U.S. Bank or other fiduciary, shall be afforded the maximum deference permitted by law.

Time limitations for commencing a claim

You must submit your claim for benefits within one year after whichever is earliest – the date on which you were denied benefits or received benefits at a different level than you believed the Program provides, or the date you knew or reasonably should have known of the principal facts on which your claim is based. After you file your claim, you must complete the entire claim-and-review procedure (with the exception of the external claim process) before you can sue over your claim. It is important that you include all the facts and arguments that you want considered during the claim-and-review procedure.

Time limitations for commencing a legal action

You must commence any lawsuit within the earlier of:

- Two years after you knew or reasonably should have known of the facts behind your claim; or
- Six months after the claim-and-review procedure is completed (including completion of external review if you pursue it).

Venue for legal action
Any legal action filed with respect to the Program must be filed in the federal court for Minnesota located in Hennepin County.

Applicable law for legal action
If federal law is not controlling, the Program shall be construed and enforced in accordance with the laws of the State of Minnesota (except that the state law will be applied without regard to any choice of law provisions).

Required legal information
This section includes some information you may need to know about the U.S. Bank Comprehensive Welfare Benefits Plan.

Official plan name	Plan type	Plan number
U.S. Bank Comprehensive Welfare Benefits Plan	Welfare plan	518

Reports on the plans are identified and filed with the federal government using an Employer Identification Number (EIN) assigned by the Internal Revenue Service. The EIN for U.S. Bank is 41-0255900. The address of the Plan Sponsor is:

U.S. Bancorp Center
800 Nicollet Mall
Minneapolis, MN 55402

Amendment or termination of the plans
U.S. Bank has reserved the right to amend the Plan, including any program or option offered under the Plan, by written action of the Benefits Administration Committee of U.S. Bank at any time, for any reason and in any respect at its sole discretion. The right of U.S. Bank to amend or terminate the Plan includes, but is not limited to, changes in the eligibility requirements, premiums or other payments charged, benefits provided and termination of all or a portion of the coverage provided under the plans, programs or options offered under the Plan. If a plan is amended or terminated, you will be subject to all the changes effective as a result of such amendment or termination, and your rights will be reduced, terminated, altered or increased accordingly, as of the effective date of the amendment or termination. You do not have ongoing rights to any plan benefit, other than payment of any covered health services you incurred or benefits to which you become otherwise entitled prior to the plan amendment or termination.

If the welfare plans are terminated and replaced by new plans, you can enroll in the new plans if you meet eligibility requirements. If new plans are not established, you may be eligible to continue your retiree health care coverage or, under certain circumstances, to convert your coverage to individual policies. These individual policies will not duplicate your benefits from U.S. Bank exactly.

Recovery of excess payments and correction of errors
As a condition of the Program, U.S. Bank has a right to recover any excess benefit payments. Excess payments can occur if benefits from U.S. Bank, or from U.S. Bank and other sources combined, exceed those due to you under a U.S. Bank plan. Excess payments may also occur if benefits were

paid because of a mistake or incorrect information regarding you or your dependent's entitlement to benefits.

U.S. Bank will recover any excess amount paid to you by:

- Reducing or suspending future benefit payments;
- Requesting direct payment from you;
- Any other method allowed by law.

The company also may correct any errors that may occur in administering the Program. Erroneous contributions and/or benefit payments can be returned to the company as permitted by law. Contributions may also be returned if they do not meet the requirements for deductibility under applicable tax laws.

Reimbursement and subrogation

This Program maintains both a right of reimbursement and a separate right of subrogation. As an express condition of your participation in this Program, you agree that the Program has the subrogation rights and reimbursement rights explained below.

The Plan's right of subrogation

If you or your dependents receive benefits under this Program arising out of an illness or injury for which a responsible party is or may be liable, this Program shall be subrogated to your claims and/or your dependents' claims against the responsible party.

Obligation to reimburse the Plan

You are obligated to reimburse the Program in accordance with this provision if the Program pays any benefits and you, or your dependent(s), heirs, guardians, executors, trustees, or other representatives recover compensation or receive payment related in any manner to an illness, accident or condition, regardless of how characterized, from a responsible party, a responsible party's insurer or your own (first party) insurer. You must reimburse the Program to the full extent of benefits paid by the Program, not to exceed the amount of recovery, before you or your dependents, including minors, are entitled to keep or benefit by any payment, regardless of whether you or your dependent has been fully compensated and regardless of whether medical or dental expenses are itemized in a settlement agreement, award or verdict.

You are also obligated to reimburse the Program from amounts you receive as compensation or other payments as a result of settlements or judgments, including amounts designated as compensation for pain and suffering, non-economic damages and/or general damages. The Program is entitled to recover from any plan, person, entity, insurer (first party or third party), and/or insurance policy (including no-fault automobile insurance, an uninsured motorist's plan, a homeowner's plan, a renter's plan, or a liability plan) that is or may be liable for (1) the accident, injury, sickness or condition that resulted in benefits being paid under the Program; and/or (2) the medical, dental and other expenses incurred by you or your dependents for which benefits are paid or will be paid under the Program.

Until the Program has been fully reimbursed, all payments received by you, your dependents, heirs, guardians, executors, trustees, attorneys or other representatives in relation to a judgment or settlement of any claim of yours or of your dependent(s) that arises from the same event as to which

payment by the Program is related shall be held by the recipient in constructive trust for the satisfaction of the Program's subrogation and/or reimbursement claims. Complying with these obligations to reimburse the Program is a condition of your continued coverage and the continued coverage of your dependents.

Duty to cooperate
You, your dependents, your attorneys or other representatives must cooperate to secure enforcement of these subrogation and reimbursement rights. This means you must take no action – including, but not limited to, settlement of any claim – that prejudices or may prejudice these subrogation or reimbursement rights. As soon as you become aware of any claims for which the Program is or may be entitled to assert subrogation and reimbursement rights, you must inform the Program by providing written notification to the claims administrator of:

- The potential or actual claims that you and your dependents have or may have;
- The identity of any and all parties who are or may be liable; and
- The date and nature of the accident, injury, sickness or condition for which the Program has or will pay benefits and for which it may be entitled to subrogate or be reimbursed.

You and your dependents must provide this information as soon as possible and in any event, before the earlier of the date on which you, your dependents, your attorneys or other representatives (i) agree to any settlement or compromise of such claims; or (ii) bring a legal action against any other party.

You have a continuing obligation to notify the claims administrator of information about your efforts or your dependents' efforts to recover compensation. In addition, as part of your duty to cooperate, you and your dependents must complete and sign all forms and papers, as required by the Program and provide any other information required by the Program. A violation of the reimbursement agreement is considered a violation of the terms of the Program.

The Plan may take such action as may be necessary and appropriate to preserve its rights, including bringing suit in your name or intervening in any lawsuit involving you or your dependent(s) following injury. The Plan may require you to assign your rights of recovery to the extent of benefits provided under the Plan. The Plan may initiate any suit against you or your dependent(s) or your legal representatives to enforce the terms of the Plan. The Plan may commence a court proceeding with respect to this provision in any court of competent jurisdiction that the Plan may elect. The Plan has no obligation to notify you or your beneficiaries of the intent to exercise one or more of these rights. The failure of the Plan to provide such a notice shall not constitute a waiver of these rights.

Attorneys' fees and other expenses you incur
The Plan will not be responsible for any attorneys' fees or costs incurred by you or your dependents in connection with any claim or lawsuit against any party, unless, prior to incurring such fees or costs, the Plan in the exercise of its sole and complete discretion has agreed in writing to pay all or some portion of fees or costs. The common fund doctrine or attorneys' fund doctrine shall not govern the allocation of attorney's fees incurred by you or your dependents in connection with any claim or lawsuit against any other party and no portion of such fees or costs shall be an offset against the Plan's right to reimbursement without the express written consent of the claims administrator. The

Plan Administrator may delegate any or all functions or decisions it may have under this "Reimbursement and Subrogation" section to the claims administrator.

What may happen to your future benefits
If you or your dependent(s) obtain a settlement, judgment, or other recovery from any person or entity, including your own automobile or liability carrier, without first reimbursing the Plan, the Plan, in the exercise of its sole and complete discretion, may determine that you, your dependents, your attorneys or other representatives have failed to cooperate with the Plan's subrogation and reimbursement efforts. If the Plan determines that you have failed to cooperate the Plan may decline to pay for any additional care or treatment for you or your dependent(s) until the Plan is reimbursed in accordance with the Plan terms or until the additional care or treatment exceeds any amounts that you or your dependent(s) recover. This right to offset will not be limited to benefits for the insured person or to treatment related to the injury, but will apply to all benefits otherwise payable under the Plan for you and your dependents.

Interpretation
In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the claims administrator shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Plan Administrator and Plan Sponsor

U.S. Bancorp is the Plan Administrator and Plan Sponsor of the plans and will make determinations that may be required from time to time in the administration of the plans. U.S. Bancorp (or the claims administrator, to the extent the claims procedure for a benefit option indicates authority has been delegated to the claims administrator) will have the sole authority, discretion and responsibility to interpret and apply the terms of the plans and to determine all factual and legal questions under the plans, including eligibility and entitlement to benefits. Benefits under any plan, Program or option will be paid only if the Plan Administrator (or the person or entity to whom it has delegated authority) decides in its discretion that the claimant is entitled to them. Except as noted below for insured benefits, U.S. Bancorp is also responsible for answering questions about the plans. The address is:

U.S. Bank – EP-MN-R2BN
Benefits Administration
4000 W. Broadway
Robbinsdale, MN 55422-2299

Although U.S. Bank is ultimately accountable for the plans, a third party provides administration and customer service. For general benefits assistance and information (such as eligibility and change of address), call U.S. Bank Employee Services. Specific coverage and claim-related questions may be better addressed by calling your claims administrator; see "Whom to contact."

Insured plans, programs or options
For each insured plan, program or option, the insurance company will have the sole authority, discretion and responsibility to interpret and apply the terms of the plan, program or option insured by the company and to determine all factual and legal questions under the plan, program or option

insured by the company, including entitlement to benefits and the amount of benefit to be paid under the insurance contract, if any.

Each insurance company is responsible for the payment of all benefits offered under the plan that it insures. In no event will U.S. Bank provide a benefit under an insured plan, program or option except through the payment of the relevant insurance premium. No covered employee, dependent or other person shall have any claim or cause of action against U.S. Bank as to the payment of benefits under any insurance policy or contract. Each covered person or other claimant entitled to the payment of benefits under an insured plan shall look solely to the applicable insurance policy or contract, and not to U.S. Bank for payment of such insured benefits.

Claims administrator information

The plans and Programs listed below are administered through contracts with insurance companies or third-party administrators:

Plan, program or option	Administration	Funding
Early Retiree Medical option	United HealthCare Services, Inc. 185 Asylum Street Hartford, CT 06103-3408	This is a self-funded option funded by employer contributions and retiree contributions. U.S. Bank has committed to paying all eligible medical claims incurred under the terms of the plan. United HealthCare Services, Inc. is the medical claims administrator. Benefits are paid from the general assets of U.S. Bank.
Pharmacy claims for the Early Retiree Medical option	Optum Rx P.O. Box 650629 Dallas, TX 75265-0629	This is a self-funded option funded by employer contributions and retiree contributions. U.S. Bank has committed to paying all eligible prescription drug claims incurred under the terms of the plan Optum Rx is the pharmacy claims administrator. Benefits are paid from the general assets of U.S. Bank.
General benefit administration and customer service	U.S. Bank Employee Services	U.S. Bank has a contract with Alight Solutions to provide these services.
COBRA	U.S. Bank Employee Services	U.S. Bank has a contract with Alight Solutions to administer COBRA.
UnitedHealthcare® Group Medicare Advantage PPO Retiree Plan with Prescription Drugs Medicare-eligible retirees and their	UnitedHealthcare P.O. Box 29650 Hot Springs, AR 71903-9973	This is an insured option, funded by employer contributions and retiree contributions. U.S. Bank has a contract with UnitedHealthcare® Group Medicare Advantage PPO Plan with Prescription Drugs to administer and pay all eligible claims incurred under the

Plan, program or option	Administration	Funding
Medicare-eligible dependents		terms of the plan. Benefits are paid from the general assets of U.S. Bank.

Agent for service of legal process

If for any reason you want to seek legal action against a plan, you can serve legal process on the administrator of the plan and/or the agent for this process. The agent for legal process is:

General Counsel of U.S. Bank
U.S. Bancorp Center
800 Nicollet Mall
Minneapolis, MN 55402

Plan year

The plan year for all plans is the calendar year (Jan. 1 through Dec. 31).

Questions about plans

If you have questions regarding specific coverage or claims status, contact your claims administrator. If you have general questions about your benefit plans (such as eligibility or deadlines), contact U.S. Bank Employee Services.

Employment rights not implied

Participating in the benefit plans does not assure you continued employment or rights to benefits except as outlined by each plan.

Assignment of benefits

Except as permitted by this Summary Plan Description or by applicable Department of Labor Regulations:

- You shall not have the right to transfer any interest or claim you may have under this Plan, including claims for benefits, for breach of fiduciary duty, to receive documents or information, or any other claim or right you may have under this Plan to any party. Nor shall you have the power to anticipate, alienate, assign, sell, transfer, pledge or encumber the same;
- Nor shall the Plan recognize an assignment therefore, either in whole or in part (except as discussed in this section);
- Nor shall any benefit be subject to attachment, garnishment, execution following judgment or other legal process.

Except as may be required by law, your benefits and rights under the Plan are not subject to the claims of your creditors.

You may not assign any of your rights under the Plan to a provider, however the Plan will make direct payment of benefits to an in-network provider. This does not, however, constitute a waiver of this anti-assignment provision. Any other attempt to assign any rights under this Plan will be void. The Plan is not required to reimburse anyone other than you for covered expenses when you use

nonparticipating providers. It is your responsibility to arrange for the payment of those expenses and then get reimbursed from the Plan. Providers are not third-party beneficiaries under the Plan. You may appoint an “authorized representative” to act on your behalf solely with respect to any administrative claim for benefits you may have under Department of Labor regulations. The designation of an authorized representative, however, does not constitute an assignment of any right under this Plan and does not provide the authorized representative with the authority to file a lawsuit on his, her or your behalf.

This anti-assignment clause can only be waived in writing by a Vice President of Employee Benefits or Benefits Design. No other conduct shall be deemed a waiver of this anti-assignment clause.

ERISA – Your rights as a member of the plans

As a participant in the Retiree Health Care Program offered through U.S. Bank and described in this document, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). This section summarizes the rights you have as a participant in the Retiree Health Care Program – rights that ERISA guarantees.

Plan documents

You can examine, without charge, any of the plan documents – which are in the Plan Administrator's office in Robbinsdale, Minnesota – during normal work hours. You may also make a written request to examine, without charge, any of the plan documents at your worksite. The documents will be sent to you within 10 business days after the date of your request. If you want to examine a document, send your written request to:

U.S. Bank – EP-MN-R2BN
4000 W. Broadway
Robbinsdale, MN 55422-2299
Fax: 833-691-7958

These documents include insurance contracts, annual financial reports and the plan documents descriptions. You may get copies of these by sending a written request to the address noted above.

The Plan Administrator may make a reasonable charge for the copies ($5 per document as of the printing of this document).

Summary Annual Report

You’ll receive a summary of the Plan's annual financial report, as applicable, once a year.

Request for information

If you make a written request for material that U.S. Bank is required to provide to you, you should receive the material within 30 days of your request. However, because of matters beyond the Plan Administrator's control (for example, if your request is lost in the mail), the requested material may reach you more than 30 days after your request. If you do not receive the material you requested within 30 days, call U.S. Bank Employee Services and it will be sent to you again.

COBRA

The law provides that you and your dependents are entitled to continue medical coverage if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents will have to pay for such coverage. Review this SPD and the documents governing the plan about the rules that apply to you and your dependents COBRA continuation rights. While not covered under the provisions of COBRA, your domestic partner and/or your domestic partner's dependents may be eligible to continue coverage if there is a loss of coverage under the plan as a result of a qualifying event.

Creditable Coverage
If your dependent is enrolled in the Early Retiree Medical UHC CPN option and is/will become eligible for Medicare, you may want to compare prescription drug coverage under the U.S. Bank plan and Medicare Part D.

U.S. Bank has determined that the U.S. Bank prescription drug coverage under the Early Retiree Medical UHC CPN option is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage.

Because the U.S. Bank prescription drug coverage under the Early Retiree Medical UHC CPN option is considered to be Creditable Coverage, you can keep this coverage and you will not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

Note: The U.S. Bank Retiree Health Care Program does not impose a pre-existing condition limitation.

Plan fiduciaries
The plan fiduciaries are responsible for the proper operation of the plan. They have a duty to act prudently and in the sole interest of plan participants and beneficiaries.

Benefits claims and legal actions
If you have any questions or problems concerning any of your plan benefits or about applying for benefits, call U.S. Bank Employee Services. If you have a claim for benefits that is denied in whole or in part, you should receive a written explanation of the reason for denial. You have the right to have the Plan Administrator review and reconsider your claim.

If you have completed the appeals process, your claim for benefits is denied (as described in this SPD) and you believe you are entitled to the benefits you claimed, you can take your case to federal or state court. If you discover that a plan fiduciary is misusing the plan's money or if you are discriminated against for exercising your rights under ERISA, you can file suit in a federal court or ask the U.S. Department of Labor for help. If you make a written request for material and do not receive the material within 30 days after your request, you can bring suit if there is no valid reason for the delay. In this situation, the court can require the Plan Administrator to provide the material and pay you up to $110 a day until you receive the materials.

If you bring suit in federal or state court to protect any of the ERISA rights discussed in this section, the court will decide who will pay court costs and legal fees. If you win your case, the court may ask

that the losing party pay these costs and fees. If you lose your case – for example, if the court finds your claim is frivolous, the court may ask you to pay these costs and fees.

Exercising your ERISA rights
The law provides that you will not be fired or discriminated against in any way for the sole purpose of preventing you from getting plan benefits or from exercising the rights you have as a plan member under ERISA. If you have any questions about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave. NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HIPAA privacy notice
It is the Plan's policy to protect your medical information to the extent required by any applicable law, including Health Insurance Portability and Accountability Act (HIPAA).

However, the Plan may share your medical information with U.S. Bank, other U.S. Bank group health plans; and with others for the purposes of treatment, payment and healthcare operations and for certain other legally permitted purposes. To the extent required by law, U.S. Bank will not use any medical information about you to make employment-related decisions.

The Plan will make reasonable efforts to use, share or request only the minimum amount of information necessary to accomplish the intended purpose. You also have certain privacy-related rights, including the right to access, request restrictions on and request amendments to your health records. Details about the Plan's privacy policies, including your privacy rights, are found in the HIPAA Privacy Notice available through Your Total Rewards site.

Glossary
24/7 Virtual Visits: live, interactive audio with visual transmissions of a physician-patient encounter from one site to another using telecommunications technology provided by a UnitedHealthcare 24/7 Virtual Visits Designated Virtual Network Provider

Admission: a period of one or more days and nights while you occupy a bed and receive inpatient care in a facility

Air ambulance: medical transport by rotary wing air ambulance or fixed wing air ambulance helicopter or airplane

Allergy services: medical services related to the evaluation and management of abnormal reactions of the immune system that occur in response to otherwise harmless substances

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 or generic prescription drug product is available

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.
- Provided by a non-network physician when no other network physician is available.

Annual maximum: the cumulative highest amount that the program will pay for a particular covered medical service or prescription drug each plan year; maximums are per covered individual for services/drugs received under all U.S. Bank medical plans in that plan year

Assisted Reproductive Technology (ART): the comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs and/or embryos) to achieve pregnancy. Examples of such procedures are:

- In-vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

Autism Spectrum Disorder: a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities

Average semiprivate room rate: the average rate charged for a room with more than one bed; if a semiprivate room is not available, the average semiprivate room rate is used to calculate for payment of the claim

Benefit subsidy: the U.S. Bank contribution to the total cost if you elect medical coverage

Cellular therapy: administration of living whole cells into a patient for the treatment of disease

Claims administrator: A third party to which U.S. Bank has delegated authority to interpret and construe the terms of the self-funded medical plans and to determine all factual and legal questions under the plans with respect to all initial claims for benefits and requests for review of adverse benefit determinations. This delegated authority includes, but is not limited to, determinations of entitlement to benefits and the amounts of the benefits to be paid. The plan you are enrolled in and the service being received will determine your specific claims administrator, see "Claims administrators" and "Claims administrator information."

COBRA: The Consolidated Omnibus Budget Reconciliation Act, under which employers have an obligation to make available to covered employees and their covered dependents or covered eligible dependents of retirees the continuation of certain benefits for a period following the termination of the employment relationship or the occurrence of certain other qualifying events, if they result in loss of coverage

Coinsurance: a percentage of the cost of the service (the lesser of eligible expenses and the provider's actual billed charge) that you pay for covered health services once the deductible has been met; coinsurance generally depends on your plan, the service being received and if you use participating network provider or not

Copay/copayment: a payment you make on a per service basis for covered health services. Copayments are applied to the out-of-pocket maximum. Any applicable copays will be applied after the combined medical/pharmacy deductible has been satisfied, except for drugs on the Core Plus Preventive Drug List for the Early Retiree Medical option.

Cosmetic procedures: procedures or services that change or improve appearance without significantly improving physiological function as determined by UnitedHealthcare

Covered health service: a service, supply or pharmaceutical product that is eligible for benefits when performed and billed by an eligible provider; you incur a charge on the date you receive a service, order a supply or purchase a drug. To be eligible, the claims administrator needs to determine that it's 1) 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; 2) medically necessary; 3) described as covered in this SPD; 4) provided to an eligible member; and 5) not otherwise listed as excluded in this SPD.

The claims administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on myuhc.com or by calling the number on your ID card. This information is available to physicians and other healthcare professionals on UHCprovider.com.

Custodial care: services for the primary purpose of meeting personal needs including giving medicine that can usually be taken without help, preparing special foods, or helping someone walk, get in and out of bed, dress, eat, bathe or use the toilet; does not include skilled care; can be provided by people without professional skills or training; custodial care is not covered by the U.S. Bank Retiree Health Care Program

Deductible: the per plan year amount of eligible expenses you must pay toward covered health services before you and the medical plan begins to share covered expenses

Definitive drug test: a test to identify specific medications, illicit substances and metabolites and is qualitative or quantitative to identify possible use or non-use of a drug

Designated provider: a provider and/or facility that:

- Has entered into an agreement with the claims administrator, or with an organization contracting on the claims administrator's behalf, to provide covered health services for the treatment of specific diseases or conditions; or
- The claims administrator has identified through the claims administrator's designation programs as a designated provider. Such designation may apply to specific treatments, conditions and/or procedures.

A designated provider may or may not be located within your geographic area. Not all network hospitals or network physicians are designated providers. You can find out if your provider is a designated provider by contacting the claims administrator at myuhc.com or the number on your ID card.

Designated Virtual Network Provider: a provider or facility that has entered into an agreement with the claims administrator, or with an organization contracting on the claims administrator's behalf, to deliver covered health services through live audio with video technology or audio-only

Domestic partnership: an ongoing and committed spouse-like relationship between adults of the same or opposite gender. If you are in a qualified domestic partnership, your domestic partner is eligible for this benefit.

A domestic partnership is **qualified** if the partners are registered with any state or local governmental domestic partner registry, or all of the criteria below are met:

- The partners have an ongoing and committed spouse-like relationship.
- The partners intend to continue their relationship indefinitely.
- The partners are:
  – both 18 years of age or older and competent to enter into a contract;
  – not legally married to each other;
  – not legally married to, nor the domestic partner of, anyone else; and
  – not related by blood closer than permitted by marriage law in their state of residence.
- The partners share a principal residence and intend to do so indefinitely.
- The partners are responsible for the direction and financial management of their household and are jointly responsible for each other's financial obligations.

Domestic partnerships are not subject to any requirements for proof of relationship or waiting periods that are not also applied to marriages. A domestic partner registry certificates or the U.S. Bank Domestic Partner Affidavit are accepted as fully equivalent to marriage certificates.

Durable medical equipment (DME): equipment that is medically necessary, able to withstand repeated use, used primarily for a medical purpose, useful only to a person who is ill, appropriate for use in the patient's home and prescribed by a physician; does not include such things as hot tubs, whirlpool baths, vehicle lifts, waterbeds, air conditioners or purifiers, heat appliances, dehumidifiers, computers or exercise equipment

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 under "Eligible expenses"

Eligible expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

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

Emergency: a critical condition that starts suddenly and requires immediate treatment to preserve or stabilize your life, limb(s), eye(s) or health

Emergency health services: with respect to an emergency, include the following:

- An appropriate medical screening examination 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, to stabilize the patient (regardless of the department of the hospital in which such further exam or treatment is provided).
- 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:
  - The attending emergency physician or treating provider determines the patient is able to travel using non-medical 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.
  - The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
  - The patient is in such a condition, as determined by the Secretary, to receive information as stated above and to provide informed consent in accordance with applicable law.
  - The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
  - 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.

Experimental, investigational or unproven services: medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other healthcare services, technologies,

supplies, treatments, procedures, drug therapies, medications or devices that, at the time UnitedHealthcare 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 as appropriate for the proposed use in any of the following:
  – American Hospital Formulary Service Drug Information (AHFS DI) under therapeutic uses section;
  – Elsevier Gold Standard's Clinical Pharmacology under the indications section;
  – DRUGDEX System by Micromedex under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; or
  – National Comprehensive Cancer Network (NCCN) drugs and biologics compendium category of evidence 1, 2A, or 2B.
- 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 experimental or investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.
- Only obtainable, with regard to outcomes for the given indication, within research settings.

Exceptions:

- Clinical trials for which benefits are available as described under "Clinical trials-routine patient care costs."
- If you are not a participant in a qualifying clinical trial as described under "Clinical trials-routine patient care costs" and have a sickness or condition that is likely to cause death within one year of the request for treatment, UnitedHealthcare may, at its discretion, consider an otherwise experimental or investigational service to be covered for that sickness or condition. Prior to such consideration, UnitedHealthcare must determine that, although unproven, the service has significant potential as an effective treatment for that sickness or condition.

Explanation of Benefits (EOB): the statement sent from the claims administrator following your receipt of a service and a subsequent claim being filed showing information about the service and the associated charges, any provider reduction, the amount paid by the plan (if any), and the amount that you are responsible to pay (if any). For UnitedHealthcare, a monthly Health Statement is issued in place of an EOB when at least one claim has been processed for you or a covered family member. For pharmacy, the statement sent by Optum Rx upon completion of processing a submitted paper claim or information included with the mail order prescription.

Fertility: the capability to produce offspring through reproduction following the onset of sexual maturity

Gene therapy: therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease

Genetic counseling: counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;

- An individualized discussion about the benefits, risks and limitations of genetic testing to help you make informed decisions about genetic testing; and
- Interpretation of the genetic testing results in order to guide health decisions.
- Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when covered health services for genetic testing require genetic counseling.

Genetic testing: exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer

Gestational carrier: a gestational carrier is a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

HIPAA: the Health Insurance Portability and Accountability Act, a federal law passed in 1996 that provides for portability of healthcare in certain situations — such as by limiting pre-existing condition exclusions and providing for special enrollment rights in group health plans — and protection of the privacy of patient medical records

Home health care agency: a provider licensed or certified as a home health care agency that sends health professionals and home health aides to a home to provide health services

Home infusion therapy: treatment provided in the home by a home health care agency involving the administration of nutrients, antibiotics and other drugs and fluids intravenously

Hospice care: care for terminally ill patients that are no longer receiving treatment to cure their disease, with the purpose of keeping them comfortable; an interdisciplinary team of professionals directs care with family members or friends acting as primary caregivers

Hospital: an institution that is operated as required by law and that meets both of the following:
- It is mainly engaged in providing inpatient health care services, for the short-term care and treatment of injured or sick persons. Care is provided through medical, diagnostic, and surgical facilities, by or under the supervision of a staff of physicians.
- It has 24-hour nursing services.

A hospital is not mainly a place for rest, custodial care or care of the aged. It is not a nursing home, convalescent home or similar institution.

Hospital-based facility: an outpatient facility that performs services and submits claims as part of a hospital

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 six months for women age 35 years or older.

Inpatient stay: a continuous stay that follows formal admission to a hospital, skilled nursing facility or inpatient rehabilitation facility

Intensive behavioral therapy (IBT): outpatient mental health care 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. The most common IBT is Applied Behavioral Analysis (ABA).

Intensive outpatient treatment: a structured outpatient program using criteria defined in American Society of Addiction Medicine (ASAM) as follows:

- 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 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 certain circumstances when the need for more care is finite and predictable.

Lifetime maximum: the cumulative highest amount that the Program will pay for a particular non-essential covered medical service or prescription drug during the covered person's lifetime

Maintenance medication: prescription drug (including injectable and specialty injectable drugs) taken on a long-term basis (e.g., to treat allergies, diabetes, high cholesterol or high blood pressure) or continual basis (e.g., oral contraceptives)

Medical supply: items that are not reusable and usually last less than one year (such as casts, splints, trusses, braces or crutches, blood or blood plasma and prosthetics) prescribed by a physician as medically necessary for treatment of an illness or injury

Medically necessary: healthcare services that are all of the following as determined by UnitedHealthcare or its designee, within UnitedHealthcare's sole discretion. The services must be:

- In accordance with Generally Accepted Standards of Medical Practice.

- Clinically appropriate, in terms of type, frequency, extent, 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 healthcare 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. UnitedHealthcare reserves the right to consult expert opinion in determining whether healthcare services are medically necessary. The decision to apply physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within UnitedHealthcare's sole discretion.

UnitedHealthcare develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare and revised from time to time), are available to you on myuhc.com or by calling the number on your ID card, and to physicians and other healthcare professionals on UHCprovider.com.

Member: a covered individual; can be the retiree or a covered dependent

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 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.

Network pharmacy: a pharmacy who has entered into a service agreement with the pharmacy claims administrator; you generally receive a higher level of benefits when using a network pharmacy

Network provider: a provider who has entered into a service agreement with the medical claims administrator for the network associated with a specific location and medical plan; you generally receive a higher level of benefit when using a network provider. Network providers are independent practitioners and are not employees of U.S. Bank or the claims administrator. The claims administrator's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

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; or
- Dec. 31 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 pharmacy: a pharmacy who has not entered into a service agreement with the pharmacy claims administrator; you generally receive a lower level of benefits when using a non-network pharmacy plus you will be responsible for paying the difference between the billed charge and the prescription drug amount

Non-network provider: a provider who has not entered into a service agreement with the medical claims administrator for the network associated with a specific location and medical plan; you generally receive a lower level of benefits when using a non-network provider plus you will be responsible for paying the difference between the billed charge and eligible expenses; see "Eligible expenses" and "Advocacy services"

Non-preventive service/non-routine care: a service that is performed to monitor health as a result of your medical or family history or is associated with an injury or illness

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 reimbursement rate includes a dispensing fee and any applicable sales tax.

Out-of-pocket maximum: the most you would have to pay per plan year for covered health services before any additional covered health services you incur are paid 100% (of eligible expenses) by the plan for the remainder of the year (as long as any applicable annual or lifetime maximums for certain services have not been exceeded)

Pharmaceutical product(s): U.S. Food and Drug Administration (FDA)-approved prescription medications or products administered in connection with a covered health service by a physician

Plan year: Jan. 1 through Dec. 31

Pre-implantation Genetic testing (PGT): a test performed to analyze the DNA from oocytes or embryos for human leukocyte antigen (HLA) typing or for determining genetic abnormalities. These include:

- PGT-A – for aneuploidy (formerly PGS).
- PGT-M – for monogenic disorder (formerly single-gene PGD).
- PGT-SR – for structural rearrangements (formerly chromosomal PGD).

Premium: the fixed cost you pay each month for participating; you pay this amount whether you use/receive services under the plan or not

Prescription drugs: medications, including insulin, that are required by state or federal law to be dispensed only by prescription of a health professional who is authorized by law to prescribe it

Prescription drug charge: the rate the Plan has agreed to pay UnitedHealthcare on behalf of its network pharmacies, including the applicable dispensing fee and any applicable sales tax, for a prescription drug product dispensed at a network pharmacy.

Prescription drug list: a list that categories into tiers medications or products that have been approved by the U.S. Food and Drug Administration. This list is subject to periodic change.

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 according to a prescription order or refill. A prescription drug product includes a medication that, due to its characteristics, is generally 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.
- Certain injectable medications administered in a network pharmacy.
- Certain vaccines/immunizations administered in a network pharmacy.
- 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 that can only be obtained from a pharmacy.
  - Glucose meters including continuous glucose monitors.

Presumptive drug test: a test to determine the presence or absence of drugs or a drug class in which results are indicated as negative or positive result

Preventive service: in general, a routine service that promotes good health, is performed on a regular basis, is not a result of your medical or family history, and is not associated with an injury or illness

Primary care physician: a physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general practice

Private duty nursing: nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or a home setting when any of the following are true:

- Services exceed the scope of intermittent care in the home.
- The service is provided to a covered person by an independent nurse who is hired directly by the covered person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a home health agency on a per visit basis for a specific purpose.

Provider: an individual, institution or agency that provides health services to healthcare consumers

Recognized amount: the amount which applicable deductible, coinsurance or copay 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. For the purpose of this provision, "certain network facilities" are limited to a hospital, a hospital outpatient department, a critical access hospital, an ambulatory surgical center, and any other facility specified by the Secretary.

The amount is based on either:

- An All Payer Model Agreement if adopted;
- State law; or
- 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.

Remote physiologic monitoring: the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed physician or other qualified health care professional to develop and manage a plan of treatment related to a chronic and/or acute health

illness or condition. The plan of treatment will provide milestones for which progress will be tracked by one or more remote physiologic monitoring devices. Remote physiologic monitoring services must be ordered by a licensed physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented and ongoing relationship. Remote physiologic monitoring may not be used while the patient is inpatient at a hospital or other facility. Use of multiple devices must be coordinated by one physician.

Residential treatment: treatment in a facility which provides mental health services or substance-related and addictive disorders 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.
- It offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services:
  – Room and board.
  – Evaluation and diagnosis.
  – Counseling.
  – Referral and orientation to specialized community resources.

A residential treatment facility that qualifies as a hospital is considered a hospital.

Secretary: as that term is applied in the No Surprises Act of the Consolidated Appropriations Act

Skilled care: services that are medically necessary and must be provided by licensed nurses or other providers eligible to develop, provide and evaluate care; does not include custodial care and services of a non-medical nature, even if provided by or under the direct supervision of a licensed nurse

Specialist: a physician with a concentration of training in a specific branch of medicine other than those listed for a primary care physician

Specialty drugs: high cost, genetically engineered injectables, selected compounds and selected orals designed to target and treat small patient populations with chronic, often complex diseases which require challenging regimens and a high level of expertise

Specialty pharmaceutical product: pharmaceutical products that are generally high-cost biotechnology drugs used to treat patients with certain illnesses

Subscriber: The individual who elected coverage in the plan. For retiree coverage, the subscriber is the U.S. Bank retiree. For COBRA coverage, the subscriber is the person on whose account the coverage and dependent information is maintained.

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.

Summary plan description (SPD): a document that provides comprehensive information about a given plan or Program, including eligibility provisions, coverage options and details, and claims procedures

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. These services will process at the same level as an office visit for that service. Telehealth/telemedicine does not include virtual care services provided by a 24/7 Virtual Visits Designated Virtual Network Provider.

Temporomandibular joint (TMJ): the connecting hinge between the lower jaw (mandible) and the base of the skull (temporal bone)

Therapeutic donor insemination (TDI): insemination with a donor sperm sample for the purpose of conceiving a child

Tobacco user: you have used any tobacco product — including smokeless and e-cigarettes containing nicotine — more than one time per week over the past six months

Transitional living: mental health services and substance-related and addictive disorders services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in American Society of Addiction Medicine (ASAM) criteria, that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the covered person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide stable and safe housing and the opportunity to learn how to manage activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the covered person with recovery.

Unproven services: health services, including medications and devices, regardless of the U.S. Food and Drug (FDA) approval, that are not determined to be effective for treatment of the medical condition or not determined 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, and the patient is not 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 healthcare services. These medical and drug policies are subject to change without prior notice. You can view these policies at myuhc.com.

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 covered for that sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that sickness or condition.

Urgent care: Care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent care center: a facility that provides covered health services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen sickness, injury, or the onset of acute or severe symptoms

U.S. Bank Employee Services: the U.S. Bank contact center for benefits and HR questions and transactions; see "Whom to contact" for details

Your Total Rewards (YTR): website that contains personalized data about your total rewards at the bank and links to view and manage your benefits; see "Whom to contact" for details

Whom to contact

Resource	Whom to contact	Contact information
U.S. Bank Employee Services Personalized information on your benefits via phone; representatives available 8 a.m. to 7 p.m. CT Monday through Friday (except holidays)	Questions about rate renewal, dependent eligibility, address updates, general assistance	800-806-7009
Your Total Rewards (YTR)	Detailed information about benefits.	usbank.com/benefitsandrewards

Resource	Whom to contact	Contact information
UnitedHealthcare® Group Medicare Advantage PPO Plan with Prescription Drugs Group numbers: Plan 1 – 13481 Plan 2 – 13482	To find a provider or for specific questions about medical coverage or claims, order replacement ID cards	**Pre-enrollment information:** 877-714-0178 TTY 711 8 a.m. to 8 p.m. local time, 7 days a week **Customer service department:** 800-457-8506 TTY 711 8 a.m. to 8 p.m. local time, Monday-Friday
United HealthCare Services, Inc. Group number: 186359 Network: Choice Plus **Optum Rx** Rx Bin: 610279 Rx PCN: 9999 Rx Group: U0186359	To find a provider or for specific questions about medical and pharmacy coverage or claims (including mail order prescription fills), order replacement ID cards Additional online resource that includes online provider directory, pharmacy pricing tools and forms	800-358-0114 myuhc.com uhcbenefitsusb.com