2024 Medical and Wellness Summary Plan Description

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Introduction

About this document

This is the summary plan description (SPD) for the Medical Program and Wellness Program, components 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 is applicable only to the Medical Program and the Wellness 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 following medical plans:

- Copay Advantage, and
- HSA Advantage.

This document is intended only to provide a summary of the benefits that are available under the Medical Program and the Wellness Program. The 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 SPD 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 Medical Program or the Wellness Program.

Kaiser plans

If you select a Kaiser plan, you will receive materials directly from Kaiser explaining the benefits provided and any requirements or limitations for receiving benefits. When read with the following sections of this SPD, these materials are the complete summary plan description for the Kaiser plans.

- Introduction
- Your plan options
- Costs
- Who's eligible
- Enrolling
- Situations that could affect your coverage or participation
- When you can make changes during the year
- When coverage ends
- Continuing coverage under COBRA
- Required legal information
- Whom to contact

The materials you receive from Kaiser 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.

Hawaii plan

Employees residing in Hawaii are offered coverage through UnitedHealthcare Insurance Company. If you choose to enroll in this plan, separate materials explaining the benefits provided and any requirements or limitations for receiving benefits can be found in the Hawaii Options PPO Certificate on Your Total Rewards. When read with the following sections of this SPD, these materials are the complete summary plan description for the Hawaii plan.

- Introduction
- Your plan options
- Costs
- Who's eligible
- Enrolling
- Situations that could affect your coverage or participation
- When you can make changes during the year
- When coverage ends
- Continuing coverage under COBRA
- Required legal information
- Whom to contact

The Hawaii Options PPO Certificate 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 until the next annual enrollment, 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.

Your plan options

Core plans

You may choose from these two plans:

- Copay Advantage

- HSA Advantage

While deductibles, copayments, coinsurance, out-of-pocket maximums and premiums differ, these plans generally work the same. Under both plans:

- There is a different claims administrator for medical services (UnitedHealthcare) and prescription drugs (Optum Rx).
- You choose a provider each time you need care — either in or out of your claims administrator's network. If you use a network provider, your expenses generally are covered at a higher level.
- If either your physician or your clinic leaves the network, you must select another physician or clinic affiliated with your network to receive network benefits — you may not change your medical plan before the next annual enrollment due to this circumstance.

Only the HSA Advantage plan meets the Internal Revenue Service (IRS) requirements for high deductible health plans, which means you may pair your medical plan with a tax-advantaged Health Savings Account (HSA) to save and pay for qualified medical expenses. You may be eligible to receive an HSA contribution from U.S. Bank. See the HSA program booklet for more information.

Kaiser plans

If you live in one of the locations below, you also will be offered the Kaiser Copay Advantage plan and the Kaiser HSA Advantage plan:

- Colorado – Denver/Boulder area, and Northern and Southern portions of the state
- California – San Francisco area
- California – Los Angeles area
- Washington – select counties
- Oregon - select counties

While deductibles, copayments, coinsurance, out-of-pocket maximums and premiums differ, these plans generally work the same. Under the Kaiser plans:

- You generally need to receive covered services (including medical, prescription drugs and vision) from Kaiser providers. If you receive non-emergency services from a non-Kaiser provider, you will likely receive no benefits.
- If either your physician or your clinic leaves Kaiser, you must select another Kaiser physician or clinic to receive coverage — you may not change your medical plan before the next annual enrollment due to this circumstance.
- Kaiser plans are offered through insurance contracts with Kaiser Permanente. For each Kaiser plan, Kaiser has the sole authority, discretion and responsibility to interpret and construe the plan; 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.
- If you enroll in a Kaiser plan and Kaiser merges with another company and is no longer offered by U.S. Bank or if Kaiser terminates operations during the year, you will be enrolled for the remainder of the year in the most comparable plan based on the available network in your area.
- Kaiser plans are subject to state regulations. Refer to Kaiser's materials, site or member service department for details.

Only the Kaiser HSA Advantage plan meets the Internal Revenue Service (IRS) requirements for high deductible health plans; which means you may pair your medical plan with a tax-advantaged Health Savings Account (HSA) to save and pay for qualified medical expenses. You may be eligible to receive an HSA contribution from U.S. Bank. See the HSA program booklet for more information.

Hawaii plan

If you live in Hawaii, you will be offered only the Hawaii Options PPO plan. Hawaii Options PPO is not a high deductible plan, and you will not be able to make contributions to a Health Savings Account while enrolled in this plan.

- The Hawaii Options PPO plan is offered through insurance contracts with UnitedHealthcare Insurance Company. UnitedHealthcare Insurance Company has the sole authority, discretion and responsibility to interpret and construe the option; 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 Hawaii Options PPO plan is subject to state regulations. Refer to UnitedHealthcare Insurance Company's materials for details.

Claims administrators

Medical claims administrator

United HealthCare Services, Inc. (UnitedHealthcare) is the claims administrator for medical services.

Pharmacy claims administrator

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 fertility 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 site 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 fertility services (including prescription drugs), obesity surgery and transplants. Fertility services (including prescription drugs), obesity surgery and transplants are not covered if you don't 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," "Fertility 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.

UnitedHealthcare travel and lodging allowance

When there is not a network provider within a 50-mile radius of your home zip code and you must travel at least 50 miles to receive care from a network provider, the plan provides a travel and lodging allowance for all covered health services provided by a network provider.

For additional information, call UnitedHealthcare.

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 eligible service provided by a network provider, 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 network provider.
- An annual maximum allowance of up to $4,000 per covered person will be provided for reasonable travel and lodging expenses incurred only as part of the covered health service for a covered person and travel companion. The allowance is independent of any existing medical coverage available for the covered person.

UnitedHealthcare must receive valid receipts for such expenses before being reimbursed. For the HSA Advantage plan, the expenses are subject to your plan's 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 network provider
- Taxi fares (not including limos or car services)
- Economy or coach airfare
- Parking
- Trains
- Boat
- Bus
- Tolls

Transition of care

If you are planning to enroll in a U.S. Bank medical plan and you or a covered family member is 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, you or 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. Call UnitedHealthcare or visit their site to request additional or replacement ID cards.

Costs

2024 Medical Plan costs per paycheck

Copay Advantage Plan administered by UnitedHealthcare

Coverage level	Total cost	Benefit subsidy	Employee premium	Domestic partner imputed income	Domestic partner children imputed income	Domestic partner and children imputed income
You only	$303.04	$202.54	$100.50	n/a	n/a	n/a
You + spouse/ domestic partner	$727.33	$451.43	$275.90	$303.04	n/a	n/a
You + child(ren)	$575.80	$384.85	$190.95	n/a	$303.04	n/a
You + family	$1,090.98	$694.47	$396.51	$303.04	n/a	$575.80

Premiums are subject to change annually. These costs assume you do not use tobacco.

HSA Advantage Plan administered by UnitedHealthcare

Coverage level	Total cost	Benefit subsidy	Employee premium	Domestic partner imputed income	Domestic partner children imputed income	Domestic partner and children imputed income
You only	$277.88	$233.28	$44.60	n/a	n/a	n/a
You + spouse/ domestic partner	$656.57	$519.76	$136.81	$277.88	n/a	n/a
You + child(ren)	$530.59	$443.94	$86.65	n/a	$277.88	n/a
You + family	$958.87	$791.96	$166.91	$277.88	n/a	$530.59

Premiums are subject to change annually. These costs assume you do not use tobacco.

Copay Advantage Plan administered by Kaiser

Coverage level	Total cost	Benefit subsidy	Employee premium	Domestic partner imputed income	Domestic partner children imputed income	Domestic partner and children imputed income
You only	$300.91	$200.51	$100.40	n/a	n/a	n/a
You + spouse/ domestic partner	$722.19	$446.52	$275.67	$300.91	n/a	n/a
You + child(ren)	$571.74	$381.00	$190.74	n/a	$300.91	n/a
You + family	$1,083.29	$687.15	$396.14	$300.91	n/a	$571.74

Premiums are subject to change annually. These costs assume you do not use tobacco.

HSA Advantage Plan administered by Kaiser						
Coverage level	**Total cost**	**Benefit subsidy**	**Employee premium**	**Domestic partner imputed income**	**Domestic partner children imputed income**	**Domestic partner and children imputed income**
You only	$249.66	$208.38	$41.28	n/a	n/a	n/a
You + spouse/ domestic partner	$588.81	$462.30	$126.51	$249.66	n/a	n/a
You + child(ren)	$476.96	$396.71	$80.25	n/a	$249.66	n/a
You + family	$857.25	$703.24	$154.01	$249.66	n/a	$476.96
Premiums are subject to change annually. These costs assume you do not use tobacco.						

Hawaii Options PPO Plan administered by UnitedHealthcare Insurance Company						
Coverage level	**Total cost**	**Benefit subsidy**	**Employee premium**	**Domestic partner imputed income**	**Domestic partner children imputed income**	**Domestic partner and children imputed income**
You only	$501.12	$400.62	$100.50	n/a	n/a	n/a
You + spouse/ domestic partner	$1,026.80	$750.90	$275.90	$501.12	n/a	n/a
You + child(ren)	$814.33	$623.38	$190.95	n/a	$501.12	n/a
You + family	$1,468.80	$1,072.29	$396.51	$501.12	n/a	$814.32
Premiums are subject to change annually.						
*Employee premium for you only coverage will be the lower of the cost listed above or 1.5% of Total Cash Compensation divided by 26 pays.						

Non-tobacco users pay less for coverage than tobacco users

If you or your covered spouse or domestic partner used any tobacco product (including smokeless and e-cigarettes containing nicotine) more than one time per week during the six months prior to your enrollment, you'll pay an additional $30 per pay/per tobacco user for medical plan coverage **unless** you complete(d) the U.S. Bank Stop Smoking Program in the timeframe indicated below. This does not apply to employees residing in Hawaii.

Your enrollment period	When you need to complete the U.S. Bank Stop Smoking Program
Annual enrollment for 2024 benefits and you **were** enrolled in a U.S. Bank medical plan in 2023	Jan. 1, 2023 through Dec. 31, 2023*
New hire enrollment or annual enrollment for 2024 benefits and you **were not** enrolled in a U.S. Bank medical plan in 2023	Within five months of your benefit eligibility date or the start of the plan year**

* If you complete the program by Dec. 13, 2023, the $30 deduction will not be taken in 2024. If you complete the program after Dec. 31, 2023, the $30 deduction will end as soon as administratively feasible, but you will not receive a refund of any deductions taken in 2024. Grace period applies for newly hired employees with coverage effective Aug. 1 or later (see below).

**If you do not complete the program within five months of benefits eligibility or the start of the plan year (as applicable), $30 per pay/per tobacco user will be added to your cost in the sixth month. If you complete the program following this deadline, the additional cost will be dropped as soon as administratively possible following your completion.

Your tobacco status will default to whatever it was the previous year (or to "tobacco user" if you have not previously enrolled). It is important to actively enroll in your benefits to ensure your status is correct, especially if you have quit smoking since your previous enrollment.

For more information or to enroll in the Stop Smoking Program (which consists of five calls with a quit coach), visit MyHR.

Taxability of premiums

Premiums for the coverage you elect (except for your domestic partner or the dependents of your domestic partner) are deducted from your paycheck each pay period on a before-tax basis. This reduces your taxable income and, therefore, reduces the taxes you pay. As such, the plan is governed by various Internal Revenue Service (IRS) regulations noted throughout this document.

If you cover your domestic partner and/or your domestic partner's dependents, the cost of coverage for your domestic partner and/or your domestic partner's dependent(s) (whether paid by you or by U.S. Bank) will be included in your taxable income. Before enrolling your domestic partner and/or your domestic partner's dependent(s), you are encouraged to talk with your accountant or financial advisor about the tax implications. Marrying your domestic partner during the plan year is a Qualified Status Change event and allows you to change from after-tax to before-tax deductions.

To comply with the Patient Protection and Affordable Care Act to provide useful and comparable consumer information, the cost of your medical coverage (both what you paid in premiums and your U.S. Bank-paid benefit subsidy) is reported in box 12, Code DD on your U.S. Bank W-2 form. The amount is not taxable.

Benefit subsidy

If you elect coverage, you will receive a benefit subsidy each pay period to cover a portion of your cost. The benefit subsidy is shown in the preceding tables. Any benefit subsidy you receive will be indicated on your pay advice. If you are covering a domestic partner and/or the dependents of a domestic partner, the portion of the subsidy that you receive for their coverage is added to your taxable income.

Plan highlights

The following tables provide a summary of key information about the U.S. Bank medical plans. See the information that follows the tables for important information about how the deductibles, copayments, coinsurance and maximums work. Also see the "Glossary" for definitions.

	Network provider	Non-network provider
Copay Advantage Plan		
Deductible per plan year; medical only (no pharmacy deductible)	You pay: $750/person $1,500/family	You pay: $1,500/person $3,000/family
Copayments* medical only, see "What's covered – pharmacy" for prescription drug coverage	You pay: $0 - 24/7 Virtual Visits $25 - primary care physician (PCP) $25 - convenience clinic $50 - specialist (SPEC) $50 - urgent care $250 - emergency room (ER)	You pay $250 emergency room (ER)
Coinsurance medical only, see "What's covered – pharmacy" for prescription drug coverage	You pay 20%	You pay 40%
Out-of-pocket maximum per plan year; combined pharmacy/medical	You pay: $3,000/person $6,000/family	You pay: $6,000/person $12,000/family
Plan maximums	Annual or lifetime maximums apply to certain services; see "What's covered – medical" and "What's covered – pharmacy"	
HSA Advantage Plan		
Deductible per plan year, combined pharmacy/medical	You pay: $3,200/person $5,000/family	You pay: $6,400/person $10,000/family
Coinsurance medical only, see "What's covered – pharmacy" for prescription drug coverage	You pay 30%	You pay 50%

	Network provider	Non-network provider
Out-of-pocket maximum per plan year; combined pharmacy/medical	You pay: $5,000/person $10,000/family	You pay: $10,000/person $20,000/family
Plan 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. *Copays are not subject to the deductible. The primary care physician, convenience clinic, specialist and urgent care copays only apply to the office visit charge billed. If any additional covered health services are billed as part of that office visit, those services are subject to deductible and coinsurance. The 24/7 Virtual Visits and emergency room copays are a flat copay. This means you are not responsible to pay for any additional covered health services billed beyond your copay.		

Deductibles and out-of-pocket maximums

A deductible is the amount of eligible expenses or recognized amount when applicable, that you must pay each plan year toward covered health services before you and the plan 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 plan pays 100% of eligible expenses for covered health services for the remainder of the year (subject to annual or lifetime maximum benefits for certain services).

The deductibles and out-of-pocket maximums for both plans are embedded. If you elect any coverage level other than You Only, this allows each covered family member the opportunity to get his/her covered health services paid prior to the entire family amount being met. This means:

- If you cover just yourself, you only need to meet the per person amount.
- If you cover two people (e.g., you and your spouse or you and one child), either one of you needs to meet the per person amount and the other needs to meet the difference between the per person amount and the family amount; or if neither of you meet the per person amount on your own, the two of you can jointly meet the family amount.
- If you cover three people (you plus two others) or more, any one of you needs to meet the per person deductible and the others meet the difference between the per person amount and the family amount; or if none of you meet the per person amount on your own, any combination of two or more of you may meet the family amount.

Expenses that do not apply to your deductible

- Your medical plan premiums.
- Any additional costs you're assessed for using tobacco.
- Any costs not covered by your plan.
- 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- 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 plan, 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 HSA Advantage plan, drugs on the Core Plus Preventive Drug List.
- For the Copay Advantage plan, travel and lodging expenses deemed eligible as part of the UnitedHealthcare travel and lodging allowance or Optum's Travel and Lodging Assistance Program.

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 HSA Advantage plan.

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. When a copay applies, you're responsible for paying the lesser of the copay, or the eligible expense or recognized amount when applicable. Copays are applied to the out-of-pocket maximum for both plans. For the HSA Advantage plan, 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 Copay Advantage plan, any applicable medical and prescription drug copays are not subject to the deductible. The primary care physician, convenience clinic, specialist and urgent care copays only apply to the office visit charge billed. If any additional covered health services are billed as part of that office visit, those services are subject to deductible and coinsurance. The 24/7 Virtual Visits and emergency room copay are a flat copay. This means you are not responsible to pay for any additional covered health services billed beyond your copay.

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

This table shows the coinsurance you pay after your deductible has been met for covered health services. 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." Applicable copays for the Copay Advantage plan are also included, but not subject to the deductible. The primary care physician (PCP), convenience clinic, specialist (SPEC) and urgent care copays only apply to the office visit charge billed. If any additional covered health services are billed as part of that office visit, those services are subject to deductible and coinsurance. The 24/7 Virtual Visits and emergency room copays are a flat copay. This means you are not responsible to pay for any additional covered health services billed beyond your copay. Telehealth/telemedicine services will process at the same level as an office visit for that service. 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	Copay Advantage		HSA Advantage	
	Network	**Non-network**	**Network**	**Non-network**
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 $0 copay	Not covered	You pay 30%	Not covered
Acupuncture services	You pay 20%	You pay 40%	You pay 30%	You pay 50%
Ambulance services -emergency only				

Covered health service	Copay Advantage		HSA Advantage	
	Network	**Non-network**	**Network**	**Non-network**
1. Ground ambulance 2. Air ambulance	You pay 20% You pay 20%	You pay 20% You pay 20%	You pay 30% You pay 30%	You pay 30% You pay 30%
Ambulance services - non-emergency 1. Ground ambulance 2. Air ambulance	 You pay 20% You pay 20%	 You pay 20% You pay 20%	 You pay 30% You pay 30%	 You pay 30% You pay 30%
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.	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	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.	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.	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 copay	You pay 40%	You pay 30%	You pay 50%

Covered health service	Copay Advantage		HSA Advantage	
	Network	Non-network	Network	Non-network
Dental-related services 1. Accident-related 2. Cleft lip and palate 3. Dental hospital services	 You pay $50 SPEC copay You pay 20% You pay 20%	 You pay 40% You pay 40% You pay 40%	 You pay 30% You pay 30% You pay 30%	 You pay 50% You pay 50% You pay 50%
Diabetes services 1. Diabetes self-management training/diabetic eye examinations/foot care 2. Diabetes equipment 3. Diabetes supplies	 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. Benefits for diabetes equipment will be the same as those stated under "Durable medical equipment (DME) and medical supplies" in this section. 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.	 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. Benefits for diabetes equipment will be the same as those stated under "Durable medical equipment (DME) and medical supplies" in this section. 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.	 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. Benefits for diabetes equipment will be the same as those stated under "Durable medical equipment (DME) and medical supplies" in this section. 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.	 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. Benefits for diabetes equipment will be the same as those stated under "Durable medical equipment (DME) and medical supplies" in this section. 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 20%	You pay 40%	You pay 30%	You pay 50%
Emergency health services - outpatient	You pay $250 ER copay	You pay $250 ER copay	You pay 30%	You pay 30%
Enteral nutrition	You pay 20%	You pay 40%	You pay 30%	You pay 50%
Fertility services Services must be received at a designated Fertility Solutions provider.	Depending upon where the covered health service is	Not covered	Depending upon where the covered health service is	Not covered

Covered health service	Copay Advantage		HSA Advantage	
	Network	**Non-network**	**Network**	**Non-network**
Treatment for the diagnosis and treatment of the underlying cause of infertility will be covered as shown under "Outpatient surgery, diagnostic and therapeutic services" and "Physician office services" in this section.	provided, benefits will be the same as those stated under each covered health service category in this section.		provided, benefits will be the same as those stated under each covered health service category in this section.	
Gender dysphoria services	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.	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.
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 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 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 20%	You pay 40%	You pay 30%	You pay 50%
Home health care	You pay 20%	You pay 40%	You pay 30%	You pay 50%
Hospice care	You pay 20%	You pay 40%	You pay 30%	You pay 50%
Hospital – inpatient stay	You pay 20%	You pay 40%	You pay 30%	You pay 50%
Injections received in a physician's office 1. Preventive 2. Non-preventive	 The plan pays 100% You pay 20% per injection	 Not covered You pay 40% per injection	 The plan pays 100% You pay 30% per injection	 Not covered You pay 50% per injection
Maternity services 1. Hospital services 2. Prenatal office visits	 You pay 20% The plan pays	 You pay 40% You pay 40%	 You pay 30% The plan pays	 You pay 50% You pay 50%

Covered health service	Copay Advantage		HSA Advantage	
	Network	**Non-network**	**Network**	**Non-network**
3. Postpartum office visits	100% The plan pays 100%	You pay 40%	100% The plan pays 100%	You pay 50%
Mental health 1. Inpatient	You pay 20%	You pay 40%	You pay 30%	You pay 50%
2. Outpatient	You pay 20%	You pay 40%	You pay 30%	You pay 50%
3. Office visit	The plan pays 100%	The plan pays 100%	The plan pays 100%	The plan pays 100%
4. Virtual Behavioral Therapy and Coaching program	The plan pays 100%	Not applicable	The plan pays 100%	Not applicable
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.	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	You pay 20%	You pay 40%	You pay 30%	You pay 50%
2. Outpatient	You pay 20%	You pay 40%	You pay 30%	You pay 50%
3. Office visit	The plan pays 100%	The plan pays 100%	The plan pays 100%	The plan pays 100%
Nutritional counseling	You pay 20%	You pay 40%	You pay 30%	You pay 50%
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	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 20%	You pay 40%	You pay 30%	You pay 50%
Outpatient surgery, diagnostic and therapeutic services	You pay 20%	You pay 40% (no coverage for dialysis services)	You pay 30%	You pay 50% (no coverage for dialysis services)
Physician fees for surgical and medical services	You pay 20%	You pay 40%	You pay 30%	You pay 50%
Physician office services 1. Primary care	You pay $25 PCP	You pay 40%	You pay 30%	You pay 50%

Covered health service	Copay Advantage		HSA Advantage	
	Network	**Non-network**	**Network**	**Non-network**
	copay			
2. Specialist	You pay $50 SPEC copay	You pay 40%	You pay 30%	You pay 50%
Prescription drugs	See "What's covered – pharmacy"	See "What's covered – pharmacy"	See "What's covered – pharmacy"	See "What's covered – pharmacy"
Preventive care services	The plan pays 100%	Not covered	The plan pays 100%	Not covered
Prosthetic devices	You pay 20%	You pay 40%	You pay 30%	You pay 50%
Reconstructive procedures	You pay 20%	You pay 40%	You pay 30%	You pay 50%
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 20%	You pay 40%	You pay 30%	You pay 50%
Skilled nursing facility/inpatient rehabilitation facility services	You pay 20%	You pay 40%	You pay 30%	You pay 50%
Spinal treatment, chiropractic and osteopathic manipulative therapy	You pay 20%	You pay 40%	You pay 30%	You pay 50%
Substance-related and addictive disorders				
1. Inpatient	You pay 20%	You pay 40%	You pay 30%	You pay 50%
2. Outpatient	You pay 20%	You pay 40%	You pay 30%	You pay 50%
3. Office visit	The plan pays 100%	The plan pays 100%	The plan pays 100%	The plan pays 100%
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.	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 designated Transplant Resource Services (TRS) provider. All other transplantation services (except Cornea transplants) must be received at a designated (TRS) provider.	Depending upon where the covered health service is provided, benefits will be the same as those stated under each covered health	Not covered	Depending upon where the covered health service is provided, benefits will be the same as those stated under each covered health	Not covered

Covered health service	Copay Advantage		HSA Advantage	
	Network	**Non-network**	**Network**	**Non-network**
	service category in this section.		service category in this section.	
2. Cornea transplants are not required to be performed at a designated TRS provider for you to receive network benefits.	You pay 20%	You pay 40%	You pay 30%	You pay 50%
Urgent care services	You pay $50 copay	You pay 40%	You pay 30%	You pay 50%
Urinary catheters	You pay 20%	You pay 40%	You pay 30%	You pay 50%

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

For the Copay Advantage plan, if you are admitted as an inpatient to a hospital directly from the emergency room or within 24 hours of receiving outpatient emergency treatment for the same condition, you will not have to pay the copay for emergency health services. The benefits for an inpatient stay in a network hospital will apply instead.

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.

Fertility services

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

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

All fertility 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 therapeutic services for the treatment of fertility 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. ART procedures include but are not limited to:
  – Egg/oocyte retrieval.

  - Fresh or frozen embryo transfer.
  - Intracytoplasmic sperm injection (ICSI).
  - Cryopreservation and storage of embryos for 12 months.
  - Embryo biopsy for Pre-implantation Genetic Testing for a Monogenic Disorder (PGT-M) or Structural Rearrangement (PGT-SR).
- 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, including but not limited to: 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 Pre-implantation Genetic Testing for Aneuploidy (PGT-A) used to select embryos for transfer in order to increase the chance for conception.
- 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.

You do not need to have a diagnosis of infertility to be eligible to receive coverage for the services described above.

Treatment for the diagnosis and treatment of the underlying cause of infertility 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 fertility 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."

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

Only charges for the following apply to the fertility lifetime maximum:
- Fertility treatments.
- Surgeon.
- Assistant surgeon.
- Anesthesia.
- Lab tests.
- Specific injections.

The Optum Travel and Lodging Assistance Program is not available for Fertility Solutions.

Gender dysphoria services

The following gender dysphoria benefits, referred to as transgender services, are based on the Standards of Care published by the World Professional Association for Transgender Health (WPATH). All transgender services that meet the prior authorization criteria are subject to the most current Standards of Care published by WPATH. The below reflects those Standards of Care as contained in Version 8. This list is not exhaustive; any services listed in the most recent WPATH Standards of Care would be covered. There is no coverage for services performed outside the United States.

There is no lifetime maximum for covered transgender services as outlined in this summary plan description (SPD) and in the WPATH Standards of Care.

Prior authorization requirement for medical and surgical treatment
There is no non-authorization penalty if prior authorization is not obtained; however, if authorization is not obtained and it's determined when the claim is processed that services did not meet the applicable prior authorization criteria requirements for that service, you will be liable for all of the charges.

Prior authorization criteria:

- **Adult hormone therapy:** Written documentation or a letter is required to recommend gender-affirming medical and surgical treatment (GAMST) from a health care professional who has competencies in the assessment of transgender and gender diverse people to include the following:
  - Gender incongruence is marked and sustained.
  - Meets diagnostic criteria for gender incongruence prior to gender-affirming hormone treatment in regions where a diagnosis is necessary to access health care.
  - Demonstrates capacity to consent for the specific gender-affirming hormone treatment.
  - Other possible causes of apparent gender incongruence have been identified and excluded.
  - Mental health and physical conditions that could negatively impact the outcome of treatment have been assessed, with risks and benefits discussed.
  - Understands the effect of gender-affirming hormone treatment on reproduction and they have explored reproductive options.
- **Adult surgery:** Written documentation or a letter is required to recommend gender-affirming medical and surgical treatment (GAMST) from a health care professional who has competencies in the assessment of transgender and gender diverse people to include the following:
  - Gender incongruence is marked and sustained.
  - Meets diagnostic criteria for gender incongruence prior to gender-affirming surgical intervention in regions where a diagnosis is necessary to access health care.
  - Demonstrates capacity to consent for the specific gender-affirming surgical intervention.
  - Understands the effect of gender-affirming surgical intervention on reproduction and they have explored reproductive options.
  - Other possible causes of apparent gender incongruence have been identified and excluded.
  - Mental health and physical conditions that could negatively impact the outcome of gender-affirming surgical intervention have been assessed, with risks and benefits discussed.
  - Stable on their gender affirming hormonal treatment regime unless hormone therapy is either not desired or is medically contraindicated.
- **Adolescent* hormonal therapy or puberty blocking agents:** Written documentation or a letter is required to recommend gender-affirming medical and surgical treatment (GAMST), only one letter of assessment from a member of the multidisciplinary team is needed. This letter needs to reflect the assessment and opinion from the team that involves both medical and mental health professionals (MHPs) to include the following:
  - A comprehensive biopsychosocial assessment including relevant mental health and medical professionals.
  - Involvement of parent(s)/guardian(s) in the assessment process unless their involvement is determined to be harmful to the adolescent or not feasible.
  - Gender diversity/incongruence is marked and sustained over time.
  - Meets the diagnostic criteria of gender incongruence in situations where a diagnosis is necessary to access health care.
  - Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment.
  - Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally.
  - Informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility.

  - Reached Tanner stage 2.
- **Adolescent* surgery:** Written documentation or a letter is required to recommend gender-affirming medical and surgical treatment (GAMST), only one letter of assessment from a member of the multidisciplinary team is needed. This letter needs to reflect the assessment and opinion from the team that involves both medical and mental health professionals (MHPs) to include the following:
  - A comprehensive biopsychosocial assessment including relevant mental health and medical professionals.
  - Involvement of parent(s)/guardian(s) in the assessment process unless their involvement is determined to be harmful to the adolescent or not feasible.
  - Gender diversity/incongruence is marked and sustained over time.
  - Meets the diagnostic criteria of gender incongruence in situations where a diagnosis is necessary to access health care.
  - Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment.
  - Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally.
  - Informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility.
  - At least 12 months of gender-affirming hormone therapy or longer, if required, to achieve the desired surgical result for gender-affirming procedures, including breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty, and facial surgery as part of gender-affirming treatment unless hormone therapy is either not desired or is medically contraindicated.

*Begins at the start of puberty to legal age 18

Benefits for gender dysphoria include:

- Mental health
  - Visits for purposes of assessment, diagnosis, referral letters and treatment of gender dysphoria, transsexualism or gender identity disorder.
  - Psychotherapy for gender dysphoria and associated co-morbid psychiatric diagnoses.
- Hormones (see prior authorization criteria above)
  - Laboratory tests to monitor hormone levels.
  - Cross-sex hormone therapy administered by a medical provider (e.g., during an office visit) is provided by UnitedHealthcare as described under “Injections received in a physician’s office.”
  - Cross-sex hormone therapy dispensed from a pharmacy is provided by Optum Rx. See “What’s covered – pharmacy” for more information.
  - Puberty suppressing medication injected or implanted by a medical provider in a clinical setting is provided by UnitedHealthcare as described under “Injections received in a physician’s office.”
- Breast/chest surgery (see prior authorization criteria above)
  - Mastectomy
    - Mastectomy with nipple-areola preservation/reconstruction as determined medically necessary for the specific patient
    - Mastectomy without nipple-areola preservation/reconstruction as determined medically necessary for the specific patient
  - Liposuction
  - Breast reconstruction (augmentation)
    - Implant and/or tissue expander
    - Autologous (includes flap-based and lipofilling)
- Genital surgery (see prior authorization criteria above)
  - Phalloplasty (with/without scrotoplasty)
    - With/without urethral lengthening

    - With/without prosthesis (penile and/or testicular)
    - With/without colpectomy/colpocleisis
  - Metoidioplasty (with/without scrotoplasty)
    - With/without urethral lengthening
    - With/without prosthesis (penile and/or testicular)
    - With/without colpectomy/colpocleisis
  - Vaginoplasty (inversion, peritoneal, intestinal)
    - May include retention of penis and/or testicle
  - Vulvoplasty
    - May include procedures described as “flat front”
- Gonadectomy (see prior authorization criteria above)
  - Orchiectomy
  - Hysterectomy and/or salpingo-oophorectomy
- Tattoo (i.e., nipple-areola) (see prior authorization criteria above)
- Uterine transplantation (see prior authorization criteria above)
- Penile transplantation (see prior authorization criteria above)
- Hair removal
  - Hair removal from the face, body, and genital areas for gender affirmation or as part of a preoperative preparation process
  - Electrolysis
  - Laser epilation
- Facial surgery (see prior authorization criteria above)
  - Brow
    - Brow reduction
    - Brow augmentation
    - Brow lift
  - Hair line advancement and/or hair transplant
  - Facelift/mid-face lift (following alteration of the underlying skeletal structures)
    - Platysmaplasty
  - Blepharoplasty
    - Lipofilling
  - Rhinoplasty (+/- fillers)
  - Cheek
    - Implant
    - Lipofilling
  - Lip
    - Upper lip shortening
    - Lip augmentation (includes autologous and non-autologous)
  - Lower jaw
    - Reduction of mandibular angle
    - Augmentation
  - Chin reshaping
    - Osteoplastic
    - Alloplastic (implant-based)
  - Chondrolaryngoplasty

    - Vocal cord surgery
- Body contouring (see prior authorization criteria above)
  - Liposuction
  - Lipofilling
  - Implants
    - Pectoral, hip, gluteal, calf
  - Monsplasty/mons reduction
- Voice therapy
- Initial/pre-op, preventative and follow-up care:
  - Initial doctor physical exams, visits and pre-op tests.
  - Post-operative follow-up visits with surgeon(s) or primary care provider(s) as needed to ensure proper healing and adjustment.
  - Routine medical care, with periodic laboratory tests to monitor hormone levels (quarterly for the first 12 to 18 months and annually thereafter) and annual physical examinations that are respectful of and attentive to the particular physical make-up of transgender, transsexual and gender-nonconforming bodies.
  - Prescription drugs and any mental health services as an individual prepares for and recovers from gender reassignment surgery.

Eunuch

Medical options requested by the patient can be considered and prescribed, if appropriate. These options can be tailored to the individual to create a plan that reflects their specific needs and preferences. The number and type of interventions applied and the order in which these take place may differ from person to person.

Prior authorization requirement for medical and surgical treatment

There is no non-authorization penalty if prior authorization is not obtained; however, if authorization is not obtained and it's determined when the claim is processed that services did not meet the applicable prior authorization criteria requirements for that service, you will be liable for all of the charges.

Prior authorization criteria:

- Written documentation or a letter is required to recommend gender-affirming medical and surgical treatment (GAMST) from a health care professional who has competencies in the assessment of transgender and gender diverse people to include the following:
  - Gender incongruence is marked and sustained.
  - Meets diagnostic criteria for gender incongruence prior to gender-affirming hormone treatment or surgical intervention in regions where a diagnosis is necessary to access health care.
  - Demonstrates capacity to consent for the specific gender-affirming hormone treatment or surgical intervention.
  - Understands the effect of gender-affirming hormone treatment or surgical intervention on reproduction and they have explored reproductive options.
  - Other possible causes of apparent gender incongruence have been identified and excluded.
  - Mental health and physical conditions that could negatively impact the outcome of hormone treatment or gender-affirming surgical intervention have been assessed, with risks and benefits discussed.
  - Eunuch individuals seeking gonadectomy consider a minimum of six months of hormone therapy as appropriate to the transgender and gender diverse (TGD) person's gender goals before the TGD person undergoes irreversible surgical intervention (unless hormones are not clinically indicated for the individual).

Treatment options for eunuchs include:

- Hormone suppression to explore the effects of androgen deficiency for eunuch individuals wishing to become asexual, nonsexual, or androgynous.
- Orchiectomy to stop testicular production of testosterone.
- Orchiectomy with or without penectomy to alter their body to match their self-image.
- Orchiectomy followed by hormone replacement with testosterone or estrogen.

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 to the address on the back of your ID card for a medical claim 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).

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 fertility.

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, see "When you can make changes during the year."

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 (for the Copay Advantage plan, you pay $25 PCP copay for the network office visit charge billed until the deductible is met).

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.

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

The program is provided through AbleTo Therapy360 and participation is completely voluntary. For the Copay Advantage plan, there is no cost to participate. For the HSA Advantage plan, there is no cost for the initial consultation. Once your deductible is met, there is no cost to you for future services.

When you enroll in the program, you will have access to a secure online portal for monitoring your progress toward meeting all the participation criteria. You're encouraged to visit the site frequently to keep abreast of the activities you should be completing and ensure that your information is up-to-date. The site also includes links to other helpful tools and resources for behavioral health.

If you think you may be eligible to participate or would like additional information regarding the program, please call UnitedHealthcare or visit ableto.com/learnmore.

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.

The Optum Travel and Lodging Assistance Program is 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.
- Office visits (for the Copay Advantage plan, you pay $25 PCP copay for the network office visit charge billed until the deductible is met).

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 these criteria are true:

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

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. Coverage for eyeglasses and contact lenses for any other reason may be covered under the separate Vision Plan; see the Vision SPD.

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 U.S. Bank medical plans do not impose pre-existing condition limitations. This means that if you or your dependents have a pre-existing condition when enrolling in a U.S. Bank medical plan, all eligible services related to the pre-existing condition will be covered without restriction, assuming the condition itself is covered.

Preventive care services

As required by law, eligible preventive care services received from a network provider are not subject to a deductible or copay (for the Copay Advantage plan) 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 age 15 to 65 years; 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. Speech therapy also may be covered as described under "Gender dysphoria services."

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 to the address on the back of your ID card for a medical claim 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 to the address on the back of your ID card for a medical claim 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 to the address on the back of your ID card for a medical claim 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.
- Office visits (for the Copay Advantage plan, you pay $25 PCP copay for the network office visit charge billed until the deductible is met).

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 "Optum Travel and Lodging Assistance Program" for more information. Kidney transplants performed at a UnitedHealthcare network facility are not eligible for the Optum Travel and Lodging Assistance Program. Cornea transplants are also not eligible for the Optum Travel and Lodging Assistance Program.

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 & 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.

Optum Travel and Lodging Assistance Program
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 Optum 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. For the HSA Advantage plan, the expenses are subject to your plan's 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

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.

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.
- **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.
- **Gender dysphoria treatment –** medical and surgical treatment.
- **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).
- **Prosthetic devices** for items that will cost more than $1,000 per device.
- **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 in order 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 U.S. Bank medical plans cover 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 or investigational services" and "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 immunoaugmentativ**e 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** 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 that the participant is **not legally required to pay**.

Services received outside of coverage period

- Services received before plan coverage begins.
- Services received after plan 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, except as specified in "What's covered-medical." (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 UnitedHealthcare travel and lodging allowance or Optum's Travel and Lodging Assistance Program.
- 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

- Routine vision examinations, including refractive examinations to determine the need for vision correction.
- 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 fertility 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 described under "Fertility services." This exclusion does not apply to short-term storage (12 months or less) and retrieval of reproductive materials for which benefits are provided as described under "Fertility 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.
  - 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. This refers to purchasing a donor egg that has already been retrieved and is frozen.
  - 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.
- Assisted Reproductive Technology procedures done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.
- The reversal of voluntary sterilization.
- Fertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation).
- Fertility treatment following unsuccessful reversal of voluntary sterilization.
- Fertility treatment following the reversal of voluntary sterilization (tubal reversal/reanastomosis, vasectomy reversal/vasovasostomy or vasoepididymostomy).
- Fertility services not received from a designated provider, unless a gap exception has been approved by Fertility Solutions.
- 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.
- 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 certain hemophilia treatment centers that are with a specific hemophilia treatment center fee schedule that allows medications used to treat bleeding disorders to be dispensed directly to covered persons for self-administration.
- 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

Benefits are available for covered prescription drug products at either a network or non-network pharmacy and are subject to deductible (HSA Advantage plan only), copayments and/or coinsurance or other payments that vary depending on which tier of the prescription drug list the prescription drug product is listed, except as otherwise specified in this SPD.

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 or copay (for the Copay Advantage plan) and are paid 100% by the plan 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 care 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 (HSA Advantage plan only)

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- 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. Prior to enrolling, visit uhcbenefitsusb.com to view the tier status of any covered drug. 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 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.

Copay Advantage and HSA Advantage* plans		
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 HSA Advantage plan, 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 medical plan; 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, 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 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

Employees and their covered dependents enrolled in a U.S. Bank medical plan 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 plan include:

- **Fertility 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 fertility. Once you enroll, a $10,000 lifetime maximum per person applies to all eligible fertility prescription drugs. A separate $25,000 lifetime maximum per person applies to all eligible fertility services, including medical and surgical treatment; see "Fertility 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"). For the Copay Advantage plan, there is no pharmacy deductible you need to meet before the supplies are covered (applicable copay/coinsurance applies). For the HSA Advantage plan, 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 listed below apply. If you have any 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 the "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- 90-day supply and pay your applicable copay/coinsurance at a local CVS pharmacy.

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- 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, fertility 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.

What's covered – wellness

The U.S. Bank Wellness Program can help improve the health and well-being of you and your family and reduce healthcare expenses for you and U.S. Bank. Participation is free (paid for by U.S. Bank) or discounted, voluntary and completely confidential.

Optum employee assistance program (EAP)
Get practical information, resources, tools and support that can empower you in all areas of your life — personal and professional, financial, legal, health, family, relationships and more. The Optum EAP is available to U.S. Bank employees and their families in the United States. Learn more by visiting MyHR.

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 a U.S. Bank medical plan (including employees and dependents). Learn more by visiting MyHR.

Onsite health centers
We offer free onsite health centers staffed by nurse practitioners in some of our larger locations to make it easier, more convenient and more affordable to take care of your appointments for minor illnesses or medical services. Onsite health centers are available to all U.S. Bank employees regardless of work location. Learn more by visiting MyHR.

Filing claims
If you do not receive materials or services to which you believe you are entitled, call U.S. Bank Employee Services. If this does not resolve the issue, you may file a claim and seek review of that claim by submitting it 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 notify you further 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 claims determination at the above address. Your request for a final claims determination should include any documentation supporting your claim.

Termination of participation
For components of this program requiring participation in a U.S. Bank medical plan, eligibility for the program ends the day you cease to be enrolled in the U.S. Bank medical plan. You also may decline or terminate participation from various components of the program at any time, since participation is voluntary.

How benefits are paid
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
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 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 the plan 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, except as described below, you are responsible for paying, directly to the non-network provider, any difference between the amount the provider bills you and the amount 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 (including non-ancillary services that have satisfied the notice and consent criteria, but unforeseen urgent medical needs arise at the time the services are provided), 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 is provided for which notice and consent has been satisfied, 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 follows: (1) an amount negotiated by UnitedHealthcare, (2) a specific amount required by law (when required by law), or (3) an amount UnitedHealthcare has determined is typically accepted by a healthcare provider for the same or similar service or an amount that is greater than such rate when elected or directed by the plan. 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, any responsibility to pay more than the eligible expense (which includes your deductible, coinsurance and copay) is yours.

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 HSA Advantage plan 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.

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 provider coverage (plan pays 50% of $85):	$42.50	Network provider coverage (plan pays 70% of $85):	$59.50
You pay $100 minus $42.50:	$57.50	You pay $85 minus $59.50:	$25.50

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 site. 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 both the U.S. Bank medical plan 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 HSA Advantage plan and use of network providers.

	Example 1	Example 2
Total charge	$5,000	$5,000

	Example 1	Example 2
What U.S. Bank would pay if it were primary plan	$1,260 ($5,000 minus $3,200 deductible = $1,800 X 70%)	$1,260 ($5,000 minus $3,200 deductible = $1,800 X 70%)
What primary plan pays	$2,700	$1,200
What U.S. Bank plan pays	$0 Difference between what primary plan pays and what U.S. Bank plan would have paid if it were primary	$60 Difference between what primary plan pays and what U.S. Bank plan would have paid if it were primary
What you pay	$2,300 ($5,000 - $2,700)	$3,740 ($5,000 - $1,200 - $60)

When the U.S. Bank medical plan 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.
- An employee's plan is considered primary for the employee. The plan that covers the employee as a dependent is secondary.
- A plan that covers a person as an employee or as a dependent of an employee is primary over a plan that covers a person under COBRA or other continuation coverage required by statute.
- For dependent children covered by the plans of both parents, the "birthday rule" applies, which means that the plan of the parent whose birthday falls earlier in the year pays first.
- 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.

Coordination with Medicare
It is recommended you or your covered dependent call 800-MEDICARE (800-633-4227) or visit medicare.gov to determine whether Medicare or the U.S. Bank plan is primary based on your own situation.

Generally, to the extent permitted by law, the U.S. Bank plan will pay benefits second to Medicare when you or your covered dependent become eligible for Medicare, even if you or your covered dependent don't elect it. There are, however, Medicare-eligible individuals for whom the U.S. Bank plan pays benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their spouses age 65 or older (this excludes domestic partners age 65 or older*); or
- Individuals with End-Stage Renal Disease (ESRD), for a limited period of time. In this case, the U.S. Bank plan is the primary payer for the first 30 months of Medicare eligibility once dialysis begins. At the end of the 30-month period, Medicare will become the primary payer; or

- If you began receiving Long-Term Disability (LTD) benefits prior to July 1, 2020, and have been on LTD for at least six months, claims will be processed assuming you are enrolled in Medicare Part A and B once you reach age 65 or two years have passed since you were awarded Social Security benefits (whichever occurs first). If you began receiving LTD benefits July 1, 2020 or later, the U.S. Bank plan will continue to pay primary while you remain eligible for active employee benefits (two years from the start of LTD benefits). If you elect COBRA after you lose eligibility for active employee coverage and you are eligible for Medicare based on age or disability, the plan will pay secondary to Medicare. If you do not enroll in Medicare Part A and B when the U.S. Bank plan becomes the secondary payer, you will be responsible for the portion that Medicare would have paid.

*Medicare is primary when a domestic partner is eligible for Medicare on the basis of age and the domestic partner has group health plan coverage based on the current employment status of his/her partner.

If the U.S. Bank plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts reimbursement directly from Medicare. If the provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an Explanation of Medicare Benefits (EOMB) issued by Medicare for a given service. Medicare typically reimburses such providers a percentage of its approved charge – often 80%.

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with the U.S. Bank plan benefits, will not exceed 100% of the allowable expense.

If you are eligible for, but not enrolled in Medicare, and the U.S. Bank medical plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program (as opposed to a provider who does not accept assignment of Medicare benefits), benefits will be paid on a secondary basis under the U.S. Bank plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider. When calculating the U.S. Bank plan's benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience, UnitedHealthcare will use Medicare's allowable expense for covered services as the allowable expense for both the U.S. Bank plan and Medicare.

Medicare Part B prescription drugs – For Medicare Part B program consideration, Medicare coverage must be noted as primary. (This applies if you are receiving benefits from the U.S. Bank Long-Term Disability plan.) See the U.S. Bank LTD Summary Plan Description for additional information.

Medicare covered drugs – Certain drugs and supplies are covered by Medicare Part B including diabetic supplies, nebulizer solutions, certain immunosuppressant drugs used for post-transplants and certain oral anti-cancer drugs. If you are currently eligible for Medicare Part B coverage the U.S. Bank plan will coordinate with Medicare Part B. If you wish 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 the medication or product is not eligible for coverage under Medicare Part B, medications covered under the prescription drug benefit are billed under your U.S Bank plan.

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 site at medicare.gov/supplier/home.asp or call Medicare at 1-800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

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

When another person is responsible for your covered expenses

As a condition of receiving benefits under the U.S. Bank medical plan, 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 medical plan pays expenses for which another party is liable, you are required to reimburse the plan 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 plan'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 plan's reimbursement and subrogation rights; see “Reimbursement and subrogation.”)

Who’s eligible

The U.S. Bank Medical Program offers coverage to benefit-eligible employees and their eligible dependents, as defined below. Special rules may apply to employees of companies acquired by U.S. Bank.

Employees

Eligible employees

If you are classified by U.S. Bank as follows on both payroll and personnel records, you are eligible for this benefit:

- A full-time employee, i.e., regularly scheduled to work 30 or more hours per week; or
- A regular part-time employee, i.e., regularly scheduled to work at least 20 but fewer than 30 hours per week.

If you began receiving Long-Term Disability (LTD) benefits prior to July 1, 2020, you will remain eligible during your disability benefit period.

Ineligible employees

If you are classified as follows, you are not eligible for this benefit:

- Part-time, i.e., working fewer than 20 hours per week;
- Temporary employee;
- United States citizen performing services outside the United States, unless approved by U.S. Bank;
- Non-resident alien who is not receiving earned income from U.S. Bank from sources within the United States, unless approved by U.S. Bank;
- Having received Long-Term Disability (LTD) for more than two years, if your LTD benefits started after June 30, 2020; or
- On active duty in the uniformed services or armed forces of any country (except continuation coverage as provided under the terms of the Uniformed Services Employment and Reemployment Rights Act; see “USERRA”).

People not classified by U.S. Bank as employees on both payroll and personnel records (such as leased employees, independent contractors, and other persons who are not classified as employees) are not eligible for this benefit.

The classification of an individual by U.S. Bank is conclusive and binding for purposes of determining benefit eligibility. No reclassification of a person's status, for any reason, by a third party, whether by a court, governmental agency or otherwise, without regard to whether or not U.S. Bank agrees to such reclassification, shall make the person retroactively or prospectively eligible for benefits. However, U.S. Bank, in its sole discretion, may reclassify a person as benefit-eligible on a prospective basis. Any uncertainty regarding an individual's classification will be resolved by excluding the person from eligibility.

Dependents

Eligible dependents

The following types of dependents are eligible as long as adequate documentation is provided upon request:

- 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 plan 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.

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 an employee or an employee'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.

Verification of dependent eligibility
If you elect coverage for dependents not previously enrolled or for whom current or valid documentation has not yet been submitted, you will need to provide documentation to verify the dependent's eligibility. You will receive a written request including a list of acceptable forms of documentation and the date by which the documentation must be received. In some cases, you may need to submit documentation on an annual basis. At the time your dependent eligibility verification is requested, you will have access to submit documents, monitor verification processing, or reprint request notices on Your Total Rewards.

If you do not provide documentation or the documents you provide do not verify your dependent's eligibility, that dependent will be removed from your coverage, and you may be responsible for any claims paid for that dependent. Additionally, enrolling ineligible dependents is a violation of company policy and will be treated accordingly. If U.S. Bank determines you have knowingly enrolled an ineligible dependent, you may be subject to disciplinary action up to and including termination of your employment.

U.S. Bank reserves the right to recover any and all benefit payments made for services received by ineligible dependents. You have the right to appeal decisions to remove a dependent(s) from coverage for failure to provide acceptable documentation; see "Appeals and disputes." The definition of "dependent" as described in "Who's eligible" applies to the medical plan, subject to any additional eligibility criteria as required by applicable state laws or regulations.

Enrolling
Enrollment period, deadlines and effective dates
Initial enrollment

Your enrollment period begins on your date of hire/eligibility/rehire and continues through the last day of the following month. Once you complete your enrollment, your coverage takes effect the first day of the month following your date of hire/eligibility/rehire. For example:

- If your hire date is Jan. 10, you must enroll between Jan. 10 and Feb. 28. Your coverage takes effect Feb. 1.
- If your hire date is June 1, you must enroll between June 1 and July 31. Your coverage takes effect July 1.

Annual enrollment
Annual enrollment is your yearly opportunity to elect and change your benefits. It is typically in November; the enrollment period and deadline are communicated in the fall. Annual enrollment elections generally take effect the following Jan. 1 and remain in effect for the entire plan year unless you qualify for and complete a Qualified Status Change or Health Care Special Enrollment.

Your premiums
You are responsible for your premiums as of the effective date of your coverage. For coverage effective Jan. 1, deductions begin the first paycheck of the year that your benefits take effect. For all other coverage effective dates, premiums will be deducted from your pay beginning the first pay period during which coverage becomes effective. If you complete your enrollment after your coverage effective date and received paychecks that did not include benefit deductions, retroactive pay adjustments will be made to collect the unpaid premiums. Your biweekly premiums will be doubled until paid in full.

Enrollment materials

Information about U.S. Bank benefits and annual enrollment can be accessed via MyHR. Additionally, if you are a new hire, newly eligible or rehire (rehired 31 days or more after termination), an enrollment worksheet containing your personalized benefit options and costs as well as your enrollment deadline and coverage effective date will be sent to your Secure Mailbox on Your Total Rewards (usually within a week of your date of hire). If you don't have a work email, an enrollment worksheet will be mailed to your home address. (Enrollment worksheets are not sent at annual enrollment.) You also may see your options and costs on the enrollment site.

How to enroll

You must complete your enrollment for yourself and any eligible dependents you wish to cover on Your Total Rewards on or before the required deadline for both your initial enrollment and each annual enrollment thereafter. Print and carefully review your confirmation statement to ensure it accurately reflects your elections. The confirmation statement is not a guarantee of coverage; all eligibility requirements must be met and all appropriate rules/procedures must be followed to receive coverage.

Making changes during the enrollment period

If you need to change your enrollment, you may do so before the enrollment deadline passes. For annual enrollment, make changes online via Your Total Rewards. For your initial enrollment, you will need to call U.S. Bank Employee Services. Once the deadline has passed, you may not make changes before the next annual enrollment unless you qualify for and complete a Qualified Status Change or Health Care Special Enrollment.

If you don't enroll

If you do not complete your enrollment by the deadline, you will receive and be required to pay premiums for the same medical plan and the same coverage level you had the previous year. If your previous Kaiser plan is no longer available, you will in most cases be enrolled in the comparable plan administered by UnitedHealthcare at the same coverage level you had the previous year. This election will be in effect for the rest of the plan year unless you qualify for and complete a Qualified Status Change or Health Care Special Enrollment.

If you did not have medical coverage the previous year, or if you are a new hire, rehire (31 days or more after termination) or newly eligible employee, you will receive no coverage. This election will be in effect for the rest of the plan year unless you qualify for and complete a Qualified Status Change or Health Care Special Enrollment.

Special enrollment circumstances

U.S. Bank employees related to each other
If you and your spouse/domestic partner are both employed by U.S. Bank, or if you and your dependent child under age 26 are both employed by U.S. Bank, you must choose a coverage level that will cover you and any eligible dependents

only once. For example, you may each elect the You Only coverage level if you do not have other eligible dependents. 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.

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 the applicable medical claims administrator. The medical claims administrator 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 the medical claims administrator that the child continues to meet eligibility requirements. If the child is approved as permanently disabled, U.S. Bank may require you to certify that the child continues to meet eligibility requirements. Failure to provide requested information may result in loss of coverage for the dependent.

If your child was disabled before age 26, but loses coverage under another medical plan after age 26, call U.S. Bank Employee Services for information about applying for coverage under the U.S. Bank plan.

Enrolling a dependent previously removed from coverage
If you want to re-enroll a dependent who was removed from coverage for failure to provide documentation of eligibility, you will have to speak with a U.S. Bank Employee Services representative.

If you are rehired within 30 days after termination
You do not enroll in this circumstance; the benefits you elected previously are reinstated as of your rehire date.

Following your enrollment
You may need to take additional steps following your online enrollment, including but not limited to:
- Providing your dependent's Social Security number if you did not do so during enrollment (see below).
- Providing verification of your dependent's eligibility.
- Other steps as indicated on your confirmation statement.

Dependent SSN requirement
Note: This is a separate process from verifying your dependent's eligibility.

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) via Your Total Rewards 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 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.

Enrollment questions
If you have questions about enrollment, call U.S. Bank Employee Services, use the online chat or submit a question online; see "Whom to contact" for more information.

Situations that could affect your coverage or participation
This section outlines how your coverage is affected by certain life events. It is intended to be an overview. Be sure to read the additional information as noted. You also may wish to refer to the life event guides on MyHR.

Event	How your coverage could change
Address change	Your coverage and benefit subsidy continue and your premiums continue to be deducted from your pay. You'll need to update your address using Workday or by calling U.S. Bank Employee Services. If you are enrolled in a Kaiser plan and you move out of the service area for that plan, you automatically will be placed in a comparable plan administered by Kaiser if it's available in your new area. If it's not available, you'll be enrolled in a comparable plan administered by UnitedHealthcare. Regardless, you'll receive a confirmation statement and new ID card. If you move between Southern California and Northern California, your current-year deductible and out-of-pocket maximum balances will be transferred to your new claims administrator. If you move from one Kaiser region to another (except between Northern and Southern California), your deductible and out-of-pocket maximum balances may be transferred at the discretion of your new claims administrator. If you change from Kaiser to UnitedHealthcare, your current-year deductible and out-of-pocket maximum balances will not transfer. If you are enrolled in a UnitedHealthcare plan, you will not be able to enroll in a Kaiser plan due to an address change during the year. If you move from Hawaii to another state and you were enrolled in coverage, you will have the opportunity to enroll in any available plan. If you move from another state to Hawaii and you were enrolled in coverage, you will automatically be enrolled in the Hawaii Options PPO plan the first of the month following the date of your address change. In either case, your deductible and out-of-pocket maximum balances will transfer unless you're in a Kaiser plan. At any time, you may use the modeling tool via Your Total Rewards to see if your address change will affect your medical plan.
Family and Medical Leave Act (FMLA) leave of absence	Special rules apply to FMLA leaves; if you take an FMLA leave, you may revoke your election. You may reactivate your prior election when you return to work within the same plan year. If you do not revoke your elections, the provisions listed under "Leave of absence," below apply. While you are on FMLA leave, you will have the same right as any other participant to change your benefit elections consistent with the change in status provisions described in this document.
Leave of absence	**Paid leave:** Unless you are on Long-Term Disability (LTD), your coverage and benefit subsidy continue and your premiums continue to be deducted from your pay. If you are on LTD, you will be billed for premiums. If you began receiving LTD benefits prior to July 1, 2020, your coverage continues during your disability benefit period, so long as premiums are paid. If you commenced LTD benefits after June 30, 2020, your coverage continues for two years from the date your LTD period begins, so long as premiums are paid. **Unpaid leave:** Your coverage continues. Upon your return, the normal per pay deduction will be doubled until the amount you owe is paid in full. If premiums cannot be fully paid in one calendar year, any remaining amount will be collected in the following year on an after-tax basis until full payment is received. If your leave continues beyond 60 days, you will be billed for coverage, including the previous 60-day period. If you do not pay unpaid premiums, your coverage will end retroactive to the last date you paid for coverage, and you will not be eligible for COBRA. If premiums are paid, you and your eligible dependents may qualify to continue coverage under COBRA.
Employment ends or retirement	Your coverage and benefit subsidy end at the end of the month in which your employment terminates, but you and your eligible dependents may qualify to continue coverage under COBRA. (Additional rules apply if you are receiving LTD benefits when your employment ends; see the LTD SPD for details.)
Begin severance	You and your covered dependents will be offered continuation coverage under COBRA. If you enroll by the deadline, your COBRA coverage commences the first of the month following your last day of employment. You will continue to receive any employer premiums subsidies for which you were eligible as an active employee during your severance period. You may continue coverage for the remainder of your COBRA period by paying the higher COBRA rates.

Event	How your coverage could change
Rehire	If you are rehired within 30 days of leaving, the plan, coverage level and benefit subsidy you had at the time you left will be reinstated. If you are rehired 31 or more days after your termination date, you are treated as a new hire and need to complete your enrollment by your deadline, as explained in the "Enrolling" section. If you had any unpaid premiums during the year and you are rehired within the same calendar year, they will be applied to your paychecks upon rehire.
Employment status change	**From part-time to full-time or regular part-time:** This is a Qualified Status Change and you may enroll by calling U.S. Bank Employee Services within 60 days. **From full-time or regular part-time to part-time:** Your coverage and benefit subsidy end at the end of the month in which you become ineligible, but you and your eligible dependents may qualify to continue coverage under COBRA. If you subsequently become eligible within 30 days of your ineligibility date, the plan, coverage level and subsidy you had before becoming ineligible will be reinstated.
You reach age 65 and continue working	Coverage and premiums continue through payroll deduction. Because you become eligible for Medicare, this is a Qualified Status Change and may decrease coverage by calling U.S. Bank Employee Services within 60 days after you are enrolled in Medicare. If you remain enrolled in the U.S. Bank plan and also enroll in Medicare, Medicare is generally the secondary payer. See "If you become eligible for Medicare Part D" below, and Coordination with Medicare in "When you have other coverage" for UnitedHealthcare or your Kaiser or Hawaii Options PPO plan information.
Death	Your coverage and benefit subsidy end at the end of the month in which you die, but your eligible dependents may qualify to continue coverage under COBRA.

If you become eligible for Medicare Part D

If you or your dependent is or will become eligible for Medicare, you may want to compare prescription drug coverage under the U.S. Bank plan and Medicare Part D. For the current plan year, U.S. Bank has determined that prescription drug coverage is:

- Creditable under the following plans (meaning on average for all plan participants is expected to pay out as much as the standard Medicare prescription drug coverage):
  - Copay Advantage
  - Kaiser Copay Advantage
  - Kaiser HSA Advantage
  - HSA Advantage
  - Hawaii Options PPO
- Non-creditable under the following plans (meaning on average for all plan participants is not expected to pay out as much as the standard Medicare prescription drug coverage):
  - Waived coverage

If your current U.S. Bank plan is non-creditable, or if you drop or lose your creditable U.S. Bank coverage and don't enroll in Medicare Part D when your current coverage ends, you may pay a higher premium (a penalty) if you enroll in Medicare Part D later. You generally will not incur a penalty if you are enrolled in creditable coverage at the time you become eligible for Medicare, so long as you remain enrolled in creditable coverage until you enroll in Medicare Part D.

A creditable coverage notice will be mailed to you annually once you or a covered dependent reach retirement age. You may be required to provide a copy of this notice when you enroll in a Medicare plan. For more information regarding your options, or to get help in making decisions about your coverage, visit medicare.gov.

When you can make changes during the year

The benefit elections you make during enrollment generally remain in effect for the entire plan year unless you experience a change in your employment status or family status that is considered a Qualifying Status Change event. Because you pay for this benefit with before-tax deductions, IRS rules determine which "events" qualify and what changes you may make based on a specific event. This section explains those rules and provides examples for clarification. Some events may also qualify as a Health Care Special Enrollment as described later.

Situations in which changes are permitted

The following events may be considered Qualified Status Change events. ('Dependent' as used in this section is defined in "Who's eligible" and includes eligible dependents of domestic partners.) **Bolded** events below can be changed online; for all other qualifying events, you must speak with U.S. Bank Employee Services.

- A change in your legal marital status, including **marriage, divorce, legal separation or annulment**.
- Death of a spouse.
- **Termination or commencement of a domestic partnership**.
- A change in your number of dependents, including **birth, adoption, placement for adoption**, death of a dependent, loss of custody of a dependent, or commencement or termination of legal guardianship.
- A change in the employment status of you or your dependent that affects eligibility for benefits, including:
  - termination or commencement of employment;
  - commencement of or return from a strike or lockout;
  - commencement of or return from an unpaid leave;
  - a change in worksite;
  - a change from part-time to regular part-time or full-time, or from full-time or regular part-time to part-time status; or
  - any other change in employment status that affects benefit eligibility.
- Your dependent satisfies or ceases to satisfy the eligibility requirements under the Plan.
- Your dependent is entitled to make a change in his or her elections under his or her employer's plan due to a permitted election change recognized by that plan.
- Your dependent's employer's plan has a plan year that is different from the U.S. Bank plan year.
- You or your dependent gains or loses eligibility for Medicare or Medicaid (this event does not apply to other state benefit programs).
- You receive or obtain a Qualified Medical Child Support Order that requires you or your former spouse to provide coverage for a dependent child.
- You change residence*;
- You or your eligible dependent **loses coverage under a group health plan** sponsored by a governmental or educational institution; or
- Your child was disabled before age 26, but loses coverage under another medical plan after age 26.

* Changes to your coverage due to a change in residence are generally automatic and are subject to the limitations described in "Situations that could affect your coverage or participation."

Consistency rules

If you experience a Qualified Status Change event, you can change only specific benefit elections that are on account of and correspond with your event. This is called a Consistency Rule.

Generally, to make a change to this program, the Qualified Status Change must have affected your or your family member's eligibility for coverage for this program.

If you are enrolled in this program when you experience a Qualified Status Change, you can change only your coverage level; you may not change your coverage option. For example, if you are enrolled in the Copay Advantage plan, you may not later elect the HSA Advantage plan due to a Qualified Status Change unless your status change also qualifies as a Health Care Special Enrollment. (You may, however, change your coverage option at annual enrollment.)

In addition, special Consistency Rules apply to certain Qualified Status Changes:

- **Loss of dependent eligibility:** If the Qualified Status Change is divorce, annulment, death of a dependent, or a dependent ceasing to satisfy the eligibility requirements and you are enrolled in the program, the only election change permitted is cancellation of coverage for that particular dependent. Coverage may not be cancelled for you or any other covered family member unless some other Qualified Status Change applies.
- **Eligibility for Medicare, Medicaid or CHIP:** If you or your dependent become(s) eligible for Medicare, Medicaid or CHIP, you may elect to cancel or decrease your coverage level. If you or your dependent loses eligibility for Medicare, Medicaid or CHIP, you may elect to enroll in or increase your coverage level.
- **Court-mandated coverage:** If you are required by a Qualified Medical Child Support Order to provide coverage for a child, coverage automatically will be added for the child and you will be enrolled if necessary. If your spouse is

required to provide coverage for a child covered by you under this program, you may cancel coverage for that child, but you may not cancel coverage for yourself or any other covered dependents.
- **Change in coverage of your dependent:** If your dependent is entitled to make a change to his or her coverage under his or her employer's plan due to a permitted election change or during his or her plan's annual enrollment period (if his or her employer's plan has a plan year that is different than the U.S. Bank plan year), you may make an enrollment election change that corresponds with the change made by your dependent.

Here are some examples of how these Consistency Rules apply:
- *Example 1: Pat is enrolled in medical coverage for herself, her spouse and her two children. Pat's oldest child enrolls in medical coverage under his employer's plan. Although his gain of other coverage is considered a Qualified Status Change event* allowing Pat to remove that child from coverage, it does not allow Pat to remove herself, her spouse or her younger child from coverage since only the oldest child experienced a qualifying event.
- *Example 2: Facts are the same as example 1, except Pat has only one child. The child gains other medical coverage. Pat can remove her child from coverage, but must keep coverage for herself and her spouse, because only the child experiences a qualifying event.*
- *Example 3: Chris, a U.S. Bank employee, and Lisa are engaged and each have medical coverage for only themselves through their respective employers. They get married during the plan year. After they are married, Chris may enroll Lisa based on her gain of eligibility under the U.S. Bank plan, or Chris may cancel his coverage when Lisa covers him under her employer's plan.*

Special enrollment rights under CHIPRA

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) was signed into law on Feb. 9, 2009, and extends and expands the Children's Health Insurance Program (CHIP, formerly known as the State Children's Health Insurance Program or SCHIP). CHIPRA provides for the following:
- If you or your dependent's Medicaid or CHIP coverage is terminated because you are no longer eligible, you qualify for a Health Care Special Enrollment which will allow you to enroll in U.S. Bank coverage.
- If you or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, you qualify for a Health Care Special Enrollment which will allow you to enroll in U.S. Bank coverage.

Health Care Special Enrollment

You may qualify for a Health Care Special Enrollment if you have new dependents or you or a dependent loses medical coverage through another source. Events that may qualify for a Health Care Special Enrollment during the plan year include the situations listed below. **Bolded** events below can be changed online; for all other qualifying events, you must speak with U.S. Bank Employee Services.

- Loss of other coverage for reasons such as:
  - **divorce**, legal separation, annulment or **termination of domestic partnership**;
  - death;
  - termination of employment;
  - reduction in hours;
  - ineligibility for Medicare, Medicaid or CHIP;
  - exhaustion of your COBRA coverage (if you were enrolled in COBRA through another source); or
  - termination of another employer's contribution toward the cost of coverage.
- Gaining a dependent due to:
  - **marriage**;
  - **birth, adoption**, placement for adoption/legal guardianship; or
  - **establishment of a qualified domestic partnership**.

Loss of coverage due to non-payment of premiums or termination for cause, such as making fraudulent claims or intentional misrepresentation, is not a qualifying event.

What you may change

If you qualify for a Health Care Special Enrollment, you may enroll in or make election changes to your medical coverage only. If you previously waived coverage, you may elect coverage for yourself and your eligible dependents. If you currently have coverage, you may add dependents and change your medical plan. You can change your other U.S. Bank

benefit elections if your event also is considered a Qualified Status Change. For information on the changes allowed for your event, call U.S. Bank Employee Services.

How to request a change

You must request a Qualified Status Change or Health Care Special Enrollment no later than 60 days from the date of your qualifying event. Your request cannot be accepted prior to the occurrence of the qualifying event. If you have experienced a change in the status of your marriage or domestic partnership, or you have acquired a newly eligible dependent due to birth or adoption, visit Your Total Rewards to make the appropriate changes to your benefits. If you need additional assistance, or if your qualifying event is due to loss or gain of coverage, loss or gain of eligibility other than marriage or divorce, commencement or termination of a domestic partnership, or any of the other listed Qualified Status Changes, call U.S. Bank Employee Services to speak to a representative who can explain the process and the changes you are permitted to make.

If your Qualified Status Change or Health Care Special Enrollment allows you to enroll your dependent(s) in medical coverage, you will be required to provide proof of each dependent's eligibility. Failure to provide such proof may result in your dependent being removed from coverage. All requests for Qualified Status Changes and Health Care Special Enrollments are subject to approval by U.S. Bank or its designated administrator.

When changes take effect

Your benefit changes will be effective on the first day of the month following the date you experience a Qualified Status Change or Health Care Special Enrollment and contact U.S. Bank Employee Services to make your election. There are two exceptions: (1) If your Qualified Status Change or Health Care Special Enrollment occurs on the first day of the month and you initiate your election change request on that day, your coverage becomes effective on that day; and (2) If you are adding a newborn or newly adopted child (or a child placed with you for adoption), coverage for that dependent, and for any other dependent you add due to that event, will be retroactive to the date of the event.

How your pay is affected

If your coverage is effective Jan. 1, deductions begin the first paycheck of the year that your benefits take effect. For all other coverage effective dates, deductions reflecting your new election will begin with the first pay period in which your election is effective. If your election change is entered into the system after pay is prepared, you'll have a retroactive pay adjustment either to collect any additional premiums due or to refund excess premiums. For example:

- Changes made between Dec. 2 and Jan. 1 take effect Jan. 1, and your deduction changes beginning the first paycheck of the year that your benefits take effect.
- Changes made between March 2 and April 1 take effective April 1, and your deduction changes during the pay period in which April 1 falls.

If you enroll a newborn or newly adopted child and coverage is retroactive to the date of birth or adoption, you also will have an adjustment to collect any additional premiums due from the date of birth or adoption. Premiums are not prorated, but collected for the full pay period in which coverage becomes effective. For example, if your child is born on Oct. 12 and you call U.S. Bank Employee Services on Oct. 28 and elect to change from You Plus Spouse coverage to You Plus Family coverage, you will be charged for You Plus Family coverage beginning with the pay period that Oct. 12 falls within, which will require an additional amount to be collected from your next pay(s).

Special Qualified Status Change circumstances

If you marry your domestic partner

Your marriage is a Qualified Status Change event that would allow you to elect or waive coverage as described previously. However, even if your domestic partner was enrolled in coverage prior to your marriage, you must contact U.S. Bank Employee Services to change your premiums to before-tax deduction without imputed income. This change will 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 reimbursement for medical and/or dental expenses. 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 at any time.

Generally, coverage for the child who is the subject of an eligible QMCSO will become effective on the date specified in the QMCSO, or at a later date as specified in the U.S. Bank QMCSO procedures. In addition, U.S. Bank will deduct the appropriate premiums from your paycheck 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 medical plan, as applicable.

For more information on QMCSOs and National Medical Support Notices (NMSNs) visit the Qualified Order site at QOCenter.com or link to it from Your Total Rewards.

When coverage ends

Your coverage will end on the last day of the month when one of the following events first occurs:

- Your employment with U.S. Bank ends;
- You commence severance;
- You retire;
- You die;
- You no longer satisfy the eligibility requirements, i.e., your scheduled hours on the payroll system decrease to less than 20 hours per week;
- You fail to pay any required premiums in full by the required due date;
- You request that coverage be terminated, as a result of, and consistent with, annual enrollment or a Qualified Status Change or Health Care Special Enrollment;
- 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;"
- You are on an unpaid leave of absence that is longer than 90 days (although certain exceptions may be made based on applicable state laws); or
- The plan or 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 reaching his/her 26th birthday;
- The dependent no longer satisfying the dependent criteria for participation in a plan or program;
- A decision by you to terminate coverage, as a result of, and consistent with, annual enrollment, a Qualified Status Change or a Health Care Special Enrollment; or
- Required documentation that proves your dependent's eligibility for coverage is not received. In this case, coverage for the ineligible dependent will end the first day of the month following the "verification required by date" plus 30 days.

If you commit an act, practice or omission that constitutes 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.

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.

Continuing coverage under COBRA

In some cases, you and/or your dependents 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

- You may continue only the coverage you were enrolled in prior to becoming eligible for COBRA. The same plan and level of coverage will be offered. Or, if you move to a different state, in some cases the claims administrator for your plan may change based on your new address.
- You do not have to enroll in COBRA coverage in order for your dependents to be covered. For example, if you had family coverage as an employee, you or your spouse may elect single coverage under COBRA.
- Although you may decrease coverage when enrolling in COBRA, you are not allowed to increase coverage until the next annual enrollment unless you have newly eligible dependents, or if you experience a Qualified Status Change or Health Care Special Enrollment.
- Once you are enrolled in COBRA, you have the same rights and responsibilities as active employees to change your coverage at annual enrollment or due to a Qualified Status Change or Health Care Special Enrollment. For example, you must request a Qualified Status Change or Health Care Special Enrollment within 60 days of the qualifying event. The effective days of Qualified Status Changes or Health Care Special Enrollments are the same under COBRA as for active employees.
- You must provide documentation of your dependent's eligibility for newly enrolled dependents either due to a qualifying event or those added at annual enrollment. Failure to provide such proof may result in your dependent being removed from coverage.

When you may elect COBRA and how long you may keep it

You and/or your eligible dependents may choose to continue coverage if it would otherwise end because of any of the events in the table below.

Qualifying event	Who's eligible for continuation	Maximum continuation coverage period
Your employment ends (for reasons other than gross misconduct), including retirement	You and your dependents	18 months
You become benefit-ineligible due to a **reduction in hours or change in employment status**	You and your dependents	18 months
Divorce/legal separation	Your spouse and dependent children	36 months
Termination of domestic partnership	Your domestic partner and your domestic partner's dependents	36 months
Your **death**	Your dependents	36 months
Loss of dependent status such as your dependent reaching age 26 (unless the loss is a result of an ineligible dependent being enrolled in your coverage)	Ineligible dependent(s)	36 months
Your termination of employment or reduction in hours **after** you become eligible for **Medicare**	Your dependents	36 months from the date of eligibility for Medicare or, if later, 18 months (29 months if there is a disability extension) from the date of the termination of employment or reduction in hours
Disability, as defined by Social Security, of you or your dependent	You and your dependents	11 months in addition to original 18 months, for a total of 29 months

Qualifying event	Who's eligible for continuation	Maximum continuation coverage period
Second qualifying event* after a termination or reduction in hours (e.g., death, divorce, legal separation or loss of dependent status)	Your dependents	18 months in addition to original 18 months, for a total of 36 months from the date of the initial qualifying event

Any alternative medical coverage provided by U.S. Bank after the date of your termination will run concurrently with the maximum coverage period for COBRA continuation coverage.
* Becoming eligible for Medicare after termination or reduction in hours is **not considered** a second qualifying event and there would be no change to your dependents' continuation period.

In addition to the Qualifying Events listed above, you and your dependents may have the right to continue coverage if U.S. Bank commences bankruptcy, under Title 11, United States Code.

Multiple events
If a second qualifying event affecting the same person occurs during COBRA coverage, the total months of coverage will include the months already received. For example:

- *John terminates employment on May 4, 2024, making his family eligible for 18 months of COBRA coverage effective June 1, 2024. On Sept. 10, 2024, John's daughter turns age 26. John's daughter is eligible for 36 months of COBRA coverage. Since this is a second event for John's daughter, she is eligible for only 32 additional months of coverage because she had already been on COBRA for four months at the time she turned 26. She does not get 36 months from the date she turned 26.*
- *Frank's daughter turns age 26 on May 4, 2024, making her eligible for 36 months of COBRA coverage effective June 1, 2024. On Sept. 10, 2025, Frank's son turns age 26. Now he is eligible for 36 months of COBRA coverage from Oct. 1, 2025, to Sept. 30, 2028. Because Frank's daughter's existing COBRA event does not involve Frank's son, he is eligible for the full 36 months of coverage.*

Extension of continuation coverage due to disability
An additional 11 months of continuation coverage may be purchased if any qualified beneficiary (e.g., you, your spouse/domestic partner or dependent children/domestic partner's dependent(s)) who elected COBRA continuation coverage is determined to be disabled at the time of or within 60 days of your termination of employment or reduction in hours of employment.

To purchase the additional 11 months of continuation coverage, you, or your dependent must call U.S. Bank Employee Services within 60 days of the date such a determination was made by the Social Security Administration and within the first 18 months of continuation coverage. At that time, you must provide proof of the Social Security Administration's determination of disability.

If the Social Security Administration determines that the person determined to have been disabled is no longer disabled, you or your dependent must contact U.S. Bank Employee Services within 30 days of the date of such determination.

Costs

During the COBRA continuation period you or your dependents will pay the full cost of coverage plus an additional 2% for administrative expenses each month as indicated in the table below. U.S. Bank reserves the right to change premiums at any time and as permitted by law. (There is one exception: disabled participants eligible for a total of 29 months will pay the full cost of coverage plus 2% for the first 18 months, and the full cost plus 50% for the additional 11 months.)

2024 COBRA monthly Medical Plan premiums				
	You only	**You plus spouse/ domestic partner**	**You plus child(ren)**	**You plus family**
Copay Advantage – UnitedHealthcare	$669.72	$1,607.40	$1,272.52	$2,411.07
HSA Advantage – UnitedHealthcare	$556.74	$1,336.27	$1,057.85	$2,004.35
Copay Advantage – Kaiser	$665.02	$1,596.05	$1,263.54	$2,394.07
HSA Advantage – Kaiser	$494.38	$1,186.53	$939.33	$1,779.78

2024 COBRA monthly Medical Plan premiums				
	You only	**You plus spouse/ domestic partner**	**You plus child(ren)**	**You plus family**
Hawaii Options PPO – UnitedHealthcare	$1,107.49	$2,269.24	$1,799.67	$3,246.04
Premiums are subject to change annually. Costs exclude any U.S. Bank-paid Health Savings Account (HSA) contributions because HSAs are not subject to COBRA.				

You and/or 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. You will not receive a reminder notice. Once coverage is cancelled, it will not be reinstated.

How to enroll

If you or your dependents become eligible for continued coverage because of your death, retirement, termination of employment, layoff, reduction in hours or change in employment status, you and/or your dependents will receive notification of your COBRA options to your home address within 44 days from the date your coverage ends. The notice will indicate the cost for continued coverage. However, you may enroll prior to receiving the materials. Once your termination has been reported, you may call U.S. Bank Employee Services or visit Your Total Rewards to make your elections.

If continuation is a result of divorce, legal separation, termination of domestic partnership or change in dependent status, you or 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 dependent(s) information about electing continued coverage. If you do not call U.S. Bank Employee Services within this time frame, any active coverage will be terminated retroactively to the date of ineligibility. Any COBRA coverage your dependent elects will be effective the first of the month following the date coverage ends.

For coverage to continue, you must call U.S. Bank Employee Services or visit Your Total Rewards to make your elections forms within 65 days after whichever is later:

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

Although you and/or your dependents have 65 days in which to make your decision, COBRA coverage is not reinstated back to the date active coverage ended until you and/or your dependents enroll online or by phone and make payment for coverage. Once your election form and payment are received, reactivation of coverage generally takes about three weeks. Until coverage is reactivated, you and/or your dependents must pay for services. When your coverage is reactivated, you then may submit the bills for reimbursement.

If you begin severance, your active coverage ends at the end of the month in which your employment terminates. However, you and your covered dependents will be offered continued coverage under COBRA at active employee rates through your severance period. If you enroll, your COBRA coverage commences the first of the month following the end of your employment. You can continue coverage for the remainder of your COBRA period, if applicable, by paying the full cost of coverage.

When continued coverage ends

Continued coverage will end before the 36-month, 29-month or 18-month limit and will not be reinstated if:

- You or your dependent(s) fail to pay the required premiums in full by the specified deadlines. It is your or your dependent's responsibility to make payment in full by the required due date each month; you will not receive a reminder notice. Checks returned for insufficient funds do not qualify as payment; special rules for partial payment may apply.

- You or 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 you or your dependent(s).
- U.S. Bank no longer offers group medical coverage to its employees.
- You or your dependent(s) no longer qualify as "disabled" as defined by Social Security, and you have exhausted the 18-month maximum continuation period.
- You or 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 you and/or your dependent(s) at the end of the month in which you or your dependent is deemed ineligible for continued coverage or as of the day on which U.S. Bank is notified that you or 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 you have paid premiums by the specified deadlines. If your medical coverage is cancelled due to nonpayment of premiums, coverage also will be cancelled for any other COBRA plans you have elected.

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

Appeals and disputes

This section describes the claim-and-review procedures for the medical plans, except for plans or services administered by Kaiser and UnitedHealthcare Insurance Company (for the Hawaii Options PPO plan only).

If you are enrolled in a Kaiser or Hawaii Options PPO plan, 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 Hawaii Options PPO and each Kaiser plan is fully insured. Each insurer has the sole authority, discretion and responsibility to interpret and construe the terms of the benefit plan it insures, 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 Hawaii Options PPO or any Kaiser plan. 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 plan will be administered in accordance with such eliminations or changes. The plan 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 plans

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

claims determination at the above address. Your request for a final claims 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, you can submit an appeal online by uploading the documentation that will prove the dependent is eligible. To submit an appeal online, go to MyHR and select the link for Your Total Rewards or go to usbank.com/benefitsandrewards. Select the link to Verify the Eligibility of Your Dependent(s) under Action Needed in the Message Center. You also can submit your documentation to:

Dependent Verification Center
P.O. Box 1434
Lincolnshire, IL 60069-1434
Fax: 866-961-6881

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 submit your appeal. You will be responsible for any claims incurred between the time coverage ended and the date it was reinstated. Any additional deductions will be collected from your pay as soon as administratively feasible.

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 claims 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 plan'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 plan (although currently the plan 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 plan'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 appeals 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 plan), 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 plan. 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 plan when the item or service was requested or provided;
- The claim or appeal denial does not relate to your failure to meet the plan'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 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 plan, and the plan 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 plan'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"). In 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 Plan 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 Plan 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 employee 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 medical 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 Plan, 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, or withholding U.S. Bank wages; and/or
- Any other method allowed by law.

The company also may correct any errors that may occur in administering the Plan. 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 Plan maintains both a right of reimbursement and a separate right of subrogation. As an express condition of your participation in this Plan, you agree that the Plan has the subrogation rights and reimbursement rights explained below.

The Plan's right of subrogation

If you or your dependents receive benefits under this Plan arising out of an illness or injury for which a responsible party is or may be liable, this Plan 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 Plan in accordance with this provision if the Plan 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 Plan to the full extent of benefits paid by the Plan, 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 Plan 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 Plan 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 Plan; 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 Plan.

Until the Plan 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 Plan is related shall be held by the recipient in constructive trust for the satisfaction of the Plan's subrogation and/or reimbursement claims. Complying with these obligations to reimburse the Plan 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 Plan is or may be entitled to assert subrogation and reimbursement rights, you must inform the Plan 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 Plan 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 Plan and provide any other information required by the Plan. A violation of the reimbursement agreement is considered a violation of the terms of the Plan.

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 Plan 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 Plan, 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 name(s)	Administration	Funding
Copay Advantage and HSA Advantage plans	United HealthCare Services, Inc. 185 Asylum Street Hartford, CT 06103-3408	These are self-funded plans, funded by employer contributions and employee contributions through salary reduction. U.S. Bank has committed to paying all eligible medical claims incurred under the terms of the plans. United HealthCare Services, Inc. is the medical claims administrator. Benefits are paid from

Plan, program or option name(s)	Administration	Funding
		the general assets of U.S. Bank.
Pharmacy claims under the Copay Advantage and HSA Advantage plans	Optum Rx P.O. Box 650629 Dallas, TX 75265-0629	These are self-funded plans, funded by employer contributions and employee contributions through salary reduction. U.S. Bank has committed to paying all eligible prescription drug claims incurred under the terms of the plans. Optum Rx is the pharmacy claims administrator. Benefits are paid from the general assets of U.S. Bank.
Hawaii Options PPO plan	UnitedHealthcare Insurance Company 185 Asylum Street Hartford, CT 06103-0450	This is an insured plan, funded by employer contributions and employee contributions through salary reduction. U.S. Bank has a contract with UnitedHealthcare Insurance Company to administer and pay all eligible medical claims incurred under the terms of the plan.
Kaiser Colorado plans	Kaiser Foundation Health Plan of Colorado Denver/Boulder Regional Administrative Office 10350 E. Dakota Avenue Denver, CO 80247	This is an insured plan, funded by employer contributions and employee contributions through salary reduction. U.S. Bank has a contract with Kaiser Permanente Colorado to administer and pay all eligible medical claims incurred under the terms of the plan.
Kaiser Northern California plans	Kaiser Foundation Health Plan, Inc. Northern California Region 1950 Franklin Street Oakland, CA 94612	This is an insured plan, funded by employer contributions and employee contributions through salary reduction. U.S. Bank has a contract with Kaiser Permanente Northern California to administer and pay all eligible medical claims incurred under the terms of the plan.
Kaiser Southern California plans	Kaiser Foundation Health Plan, Inc. Southern California Region 393 East Walnut Street Pasadena, CA 91188	This is an insured plan, funded by employer contributions and employee contributions through salary reduction. U.S. Bank has a contract with Kaiser Permanente Southern California to administer and pay all eligible medical claims incurred under the terms of the plan.
Kaiser Northwest plans	Kaiser Foundation Health Plan of the Northwest Kaiser Permanente Regional Administrative Office 500 NE Multnomah St. Suite 100 Portland, OR 97232	This is an insured plan, funded by employer contributions and employee contributions through salary reduction. U.S. Bank has a contract with Kaiser Northwest to administer and pay all eligible medical claims incurred under the terms of the plan.
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.
Wellness Program	U.S. Bank – EP-MN-R2BN 4000 W. Broadway Robbinsdale, MN 55422-2299	U.S. Bank administers the U.S. Bank Wellness Program.

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. You may also submit a question or chat with a representative online via Your Total Rewards. See "Whom to contact" for details.

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
- 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 Medical Program or Wellness 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 Medical Program or Wellness 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, Minn. – 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 your worksite within 10 business days after the date of your request. If you want to examine a document at your worksite, 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
For Medicare Part D creditable coverage information, see "If you become eligible for Medicare Part D."

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. N.W., 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 the 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 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 enrollment: yearly opportunity to elect and change U.S. Bank benefits; the elections you make during annual enrollment generally take effect the following Jan. 1 and remain in effect for the entire plan year unless you qualify for and complete a Qualified Status Change or Health Care Special Enrollment

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

Before-tax: prior to federal income and Social Security taxes — and commonly state and local income taxes — being deducted

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 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 or recognized amount when applicable, 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 a network provider or not

Copay/copayment: a payment you make on a per service basis for covered health services. When a copay applies, you're responsible for paying the lesser of the copay, or the eligible expense or recognized amount when applicable. Copays are applied to the out-of-pocket maximum for both plans. For the HSA Advantage plan, 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 Copay Advantage plan, any applicable copays are not subject to the deductible. The primary care physician, convenience clinic, specialist and urgent care copays only apply to the office visit charge billed. If any additional covered health services are billed as part of that office visit, those services are subject to deductible and coinsurance. The 24/7 Virtual Visits and emergency room copay are a flat copay. This means you are not responsible to pay for any additional covered health services billed beyond your copay.

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 medical plans

Deductible: the per plan year amount of eligible expenses or recognized amount when applicable, that you must pay toward covered health services before you and the medical plan begin 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 or as required by law. 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 sources or determinations that UnitedHealthcare accepts.

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.

Enrollment period: time during which benefit elections can be made or changed, including annual enrollment and initial enrollment for new benefit-eligible employees; see "Enrolling"

Experimental or investigational 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

Full-time employee: person classified by U.S. Bank on both payroll and personnel records as a full-time employee and regularly scheduled to work 30 or more hours per week

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

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

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

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

Health Care Special Enrollment: an event — such as loss of other coverage or gaining a new dependent — which allows you to change your medical plan or coverage level; see "When you can make changes during the year"

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 19 hours per week of structured programming for adults and six to 19 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

Long-Term Disability (LTD) Plan: a benefit that replaces a portion of pay if an eligible, covered employee is disabled due to illness or injury for a period longer than 26 weeks (or 90 days for 100% commission employees)

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 employee 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.

Nonbinary: individuals who experience their gender as outside the gender binary

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)

Part-time employee: person classified by U.S. Bank on both payroll and personnel records as a part-time employee and regularly scheduled to work fewer than 20 hours per week

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 pay period through payroll deduction 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. Behavioral health providers are included within the primary care physician (PCP) copay.

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

Qualified Status Changes: certain events, defined by the Internal Revenue Service, that may enable an employee to enroll or change benefit elections outside of annual enrollment; see "When you can make changes during the year"

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.

Regular part-time employee: person classified by U.S. Bank on both payroll and personnel records as a regular part-time employee and regularly scheduled to work at least 20 but fewer than 30 hours per week

Regularly scheduled hours: hours listed on the U.S. Bank payroll system, regardless of hours actually worked; used to determine benefit eligibility and some benefits

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 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

Short-Term Disability (STD) Plan: a benefit that may replace a percentage of pay if an eligible, covered employee is disabled due to illness or injury for up to 26 weeks

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. The specialist (SPEC) copay also applies to a physician assistant or nurse practitioner billing under their own contract or tax identification number.

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 active coverage, the subscriber is the U.S. Bank employee. 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 U.S. Food and Drug Administration (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): site that contains personalized data about your total rewards at the bank and links to enroll in and manage your benefits; see "Whom to contact" for details

Whom to contact

Resource	Why 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 benefit eligibility and enrollment, dependent verification, general assistance	800-806-7009
MyHR	See benefit and well-being program information and link to related sites, including YTR	itsmnow.service-now.com/myhr
Your Total Rewards (YTR)	Detailed information about benefits, enroll in your benefits, view your current elections	Link from MyHR or log in directly at usbank.com/benefitsandrewards
Kaiser – Colorado Group number: 0596	To find a provider or for specific questions about coverage or claims	303-338-3800 or 800-632-9700 kaiserpermanente.org my.kp.org/usbank
Kaiser – Northern California Group number: 29094	To find a provider or for specific questions about coverage or claims	800-464-4000 kaiserpermanente.org my.kp.org/usbank
Kaiser – Southern California Group number: 118831	To find a provider or for specific questions about coverage or claims	800-464-4000 kaiserpermanente.org my.kp.org/usbank
Kaiser – Northwest Group number: 12039	To find a provider or for specific questions about coverage or claims	800-813-2000 kaiserpermanente.org my.kp.org/usbank
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 For information prior to enrolling, including online provider directory, pharmacy pricing tools and forms	800-358-0114 myuhc.com uhcbenefitsusb.com
UnitedHealthcare Insurance Company – Hawaii Group number: 186359	To find a provider or for specific questions about medical and pharmacy coverage or claims (including mail order prescription fills),	800-358-0114 www.myuhc.com

Resource	Why to contact	Contact information
Network: Options PPO **Optum Rx** Rx Bin: 610279 Rx PCN: 9999 Rx Group: U0186359	order replacement ID cards	