# Handbook Supplement

## The Bind Plan

A component benefit program of the
UHG Inc. Group Benefits Plan

**Effective Date: January 1, 2021**

This Handbook Supplement contains important information about your Bind Health Plan coverage. It forms part of the official Summary Plan Description and Plan document for your Bind Health Plan coverage. Please keep this document with all other documents describing your medical benefits.

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# Table of Contents



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# 1. Quick Reference

This section is a quick reference guide. Please review this entire Summary Plan Description (SPD) for additional details about your coverage.

| | |
|---|---|
| **Website**<br>Access to what is covered, how much it costs, and where you can get care. | **Once enrolled:**<br>MyBind.com<br>**When enrolling:**<br>**choosebind.com/uhg**<br>**Access Code: UHG2021** |
| **Mobile Application**<br>To optimize the Plan, check your coverage, cost, and treatment options before seeking care. | MyBind mobile app<br>Once enrolled, download the Bind app from the Apple App Store or Google Play Store. |
| **Phone Numbers**<br>Who to contact to help answer any questions. | **Bind Plan Questions:**<br>**Bind Help Team**<br>1-855-472-7778<br>**Monday – Friday**<br>6:00 am to 7:00 pm Central<br><br>**Retail and Mail Order Pharmacy Questions:**<br>www.optum.com<br>1-800-356-3477<br><br>**Specialty Pharmacy Questions:**<br>www.optum.com<br>1-855-427-4682 |
| **Name of the Plan (referred herein as "Bind Plan")** | The Bind Plan, which is a component benefit program of the UHG Inc. Group Benefits Plan |
| **Plan Administrator**<br>Who is ultimately responsible for administering the Bind Plan. | UnitedHealth Group Employee Benefits Plans Administrative Committee |
| **Claims Administrator**<br>Who processes medical Claims, administers medical appeals. | Bind Benefits, Inc. |
| **Medical Claims Mailing Address**<br>Where to mail medical Claims, written inquiries, and medical Claims appeal requests. | Bind Benefits, Inc.<br>P.O. Box 211758<br>Eagan, MN 55121 |
| **Prescription Claims Mailing Address**<br>Where to mail prescription Claims, prescription appeal requests and any written inquires. | UnitedHealthcare Appeals<br>P.O. Box 30432<br>Salt Lake City, UT 84130-0432 |
| **Bind App and Website**<br>Who runs Bind Help, Bind app and websites. | Bind Benefits, Inc. |

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## 1.1 About this Document

UnitedHealth Group Incorporated (UnitedHealth Group or the Company) sponsors the UHG Inc. Group Benefits Plan. The Bind Plan is a component of the UHG Inc. Group Benefits Plan and is governed by ERISA. Benefit plans that are subject to ERISA must be summarized in a Summary Plan Description (SPD).

The SPD for the Bind Plan consists of:

- This Handbook Supplement, and
- The UHG Benefits Handbook — Health Benefits.

The SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic SPD for this Plan.

The Plan Administrator uses this dual-status document to administer the Bind Plan.

For that reason, the company has prepared this supplement to describe the health Benefits available to you and your covered family members under the Bind Plan.

## 2. How Does the Bind Personalized Health Plan Work?

The Bind personalized health plan ("Bind Plan") design allows each Participant to make informed choices about their health care, cost, and coverage needs. With the MyBind mobile app and the MyBind.com website Participants can search for available care, cost, and coverage options from any geographic location to choose the best option for them. Or Participants can call Bind Help for assistance navigating their coverage options. Eligible employees and dependents who properly enroll in the Bind Plan are referred to as "Participants" in this SPD.

The Bind Plan has features that Participants already know and understand — including, for example: no deductible; simple copayments for Covered Health Services; an annual out-of-pocket maximum; and available comprehensive coverage. The Bind Plan also has a feature that allows Participants with an Adverse Health Factor to elect and activate conditional coverages in advance of seeking care, if and when the Participant determines it is needed.

Here is how it works:

When you enroll in the Bind Plan, your coverage automatically includes substantial coverage of Physician and hospital services — including, for example: preventive care, Emergency and urgent care, office visits, inpatient and outpatient hospital visits, and prescription drugs. Your coverage also provides substantial coverage for common and/or Medically Necessary services and treatments such as, maternity care, cancer treatment, and physical therapy.

**Once enrolled in the Bind Plan, Bind coverage also includes the right to elect conditional coverages into your benefit package for 44 less-common tests, treatments, or therapies if you have an Adverse Health Factor — a new or deteriorating medical condition that coincides with the conditional coverage you need. These coverages are conditional because you must first elect and activate the coverage – at least three business days in advance of receiving the test, treatment, or therapy — in order to have coverage for such test, treatment, or therapy under the Bind Plan.**

Conditional coverages include tests, such as Upper GI Endoscopies, and treatments — including, for example, hernia repairs, hysterectomies, lumbar spine fusion, knee arthroscopies, shoulder arthroscopies, and many other condition-based services. Participants can elect and activate these coverages at any time during the Plan Year if the Participant experiences an Adverse Health Factor and the additional paycheck deductions are made.

To activate conditional coverage into your benefits package, follow the steps explained in Section 3.Participants and Plan Sponsors share in the cost of the Bind Plan. Your premium contribution amount depends on the benefit package you select and the dependents you choose to enroll.

To summarize, the Bind personalized health plan gives you cost and coverage options and allows you to customize and personalize your benefit package during the Plan Year if you experience an Adverse Health Factor.

## Preferred, High-Value Providers

You may be eligible for reduced copayments for certain Benefits and for specific condition-based programs if you use in-network Providers that Bind has designated as preferred, high-value Providers. Bind determines which in-network Providers are preferred, high-value Providers. You can learn more about preferred, high-value Providers and the impact on your copayments by using the MyBind mobile app or MyBind.com website, or call Bind Help.

## Cost of Coverage

You and UnitedHealth Group share in the cost of the Plan. Your premium contribution amount depends on the benefit package you select and the dependents you choose to enroll.

Your premium contributions are deducted from your paychecks on a pre-tax basis. Pre-tax dollars come out of your pay before federal income and Social Security taxes are withheld, and in most states, before state and local taxes are withheld. UnitedHealth Group reserves the right to change your premium contribution amount from time to time. You can obtain current premium contributions by contacting HRdirect at 800-561-0861.

Due to Internal Revenue Service rules, the premiums for eligible domestic partners and their children may receive different tax treatment. For more information, see the UHG Benefits Handbook, incorporated herein by reference.

You may earn premium discounts or other financial rewards by participating in the Rewards for Health Program offered by UnitedHealth Group. See Section 13, Attachment VII or the UHG Benefits Handbook for more details about the Rewards for Health program.

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## 3. Am I Eligible and How Do I Enroll?

You may enroll in the Bind Plan for coverage if you are an eligible employee and you meet the following requirements:

- You are eligible to participate in medical coverage under the UHG Inc. Group Benefits Plan ("UHG Plan"), as described in the UnitedHealth Group Incorporated Group Benefits Handbook (the "UHG Benefits Handbook").
- You satisfy the residence location requirements to participate in the Bind Plan, as set forth in the UHG Benefits Handbook.

You may cover your spouse or domestic partner and eligible dependent children who meet the eligibility requirements as described in the UHG Benefits Handbook.

To enroll, eligible employees must complete the enrollment process applicable to medical coverage according to the process described in the UHG Benefits Handbook.

### Electing and Activating Conditional Coverages

Once enrolled in the Bind Plan, you are eligible to elect and activate one or more conditional coverages. To elect and activate conditional coverage into your benefit package, you or your covered dependent **must** take the following steps:

(1) Choose the conditional coverage test, treatment, or therapy.

(2) Choose the Provider and location for the test, treatment, or therapy.

(3) Attest to the Adverse Health Factor.

(4) Review the total cost of the test, treatment, or therapy.

(5) Click "Activate Coverage" to complete the activation process. *

**If your covered dependent is electing and activating conditional coverage, you (as the subscriber) must complete a sixth step and finally approve the conditional coverage election to fully complete the activation process.*

You can elect and activate coverage on the MyBind mobile app or MyBind.com website or call Bind Help for assistance. If you do not elect and activate the conditional coverage needed so it is effective in advance of receiving the test, treatment, or therapy, you will not have coverage under the Bind Plan for the test, treatment, or therapy.

You must complete the steps above at least three business days in advance of receiving the conditional coverage test, treatment, or therapy. During the three-business-day waiting period before your conditional coverage is activated and effective, you may cancel the conditional coverage through the MyBind mobile app or MyBind.com website or by calling Bind Help for assistance. Alternatively, you may expressly and permanently opt out of the three-business-day waiting period,

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so that the conditional coverage is immediately active and effective. Once the conditional coverage is activated and effective, it cannot be cancelled for the duration of the conditional coverage period.

## Changes During the Year

The enrollment election you make when you are newly eligible or during the Annual Enrollment period generally must remain in effect through December 31 of the year for which it was made (other than conditional coverage). If you experience a qualified life event (including, but not limited to, the birth or adoption of a child, divorce, or loss of other coverage), you may be permitted to make a mid-year change to your enrollment election. The rules governing mid-year election changes are set forth in the UHG Benefits Handbook and incorporated herein by reference.

In addition to the mid-year change events set forth in the UHG Benefits Handbook, an Adverse Health Factor as defined by this SPD is a mid-year change event for conditional coverage only for the Bind Plan.

## Special Enrollment Rights

The rules governing Special Enrollment Rights for the Bind Plan are set forth in the UHG Benefits Handbook and incorporated herein by reference.

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# 4. When Does My Coverage Begin and End?

## 4.1 Effective Dates

Your Bind Plan coverage will be effective on the dates set forth in the UHG Benefits Handbook.

### Coverages You Must Elect and Activate

**You must first elect and activate conditional coverage for it to be effective – or in other words, if you do not first elect and activate conditional coverage, you will not have coverage under the Bind Plan for the conditional coverage test, treatment, or therapy.**

If you are already enrolled in the Bind Plan, conditional coverage is effective three business days after you complete the election and activation process, unless you expressly and permanently opt-out of the three-business-day waiting period for that specific elected and activated conditional coverage. To activate conditional coverage into your benefits package, follow the steps explained in Section 3.

If you are enrolled in the Bind Plan (or you have completed Annual Enrollment) but your coverage is not yet effective, you can call Bind Help for assistance in electing and activating conditional coverage to be effective as of the first day you are eligible to participate.

## 4.2 End Dates

Your coverage (including for conditional coverages) will terminate on the dates set forth in the UHG Benefits Handbook.

**Only with respect to conditional coverages**: 120 days after the conditional coverage Effective Date, even if the date of the conditional coverage test, treatment, or therapy falls into the subsequent Plan Year so long as you maintain the Bind Plan coverage for the subsequent Plan Year.

Paycheck deductions will continue until you have paid the full conditional coverage amount and may continue even after coverage ends.

## 4.3 Leave of Absence

The rules governing leaves of absences for the Bind Plan are set forth in the UHG Benefits Handbook and are incorporated herein by reference.

# 5. What Are My Benefits?

Claims for Benefits under the Bind Plan are payable only for Covered Health Services that are Medically Necessary.

The total cost of Covered Health Services is shared between you and the Bind Plan. Your share (including for conditional coverages) consists of premium contributions and copayments. The Bind Plan does not have a deductible. Your Bind Plan does have an out-of-pocket maximum which is the maximum amount you will pay each Plan Year for Covered Health Services.

Your premium contributions are deducted from your paychecks on a before-tax basis, or in other words, before federal income and Social Security taxes are withheld, and in most states, before state and local taxes are withheld. This gives your premium contribution a tax advantage and lowers the actual cost of your benefit package. Your paycheck deductions are subject to review, and the Plan Administrator reserves the right to change your paycheck deduction amount from time to time.

Your copayments for Covered Health Services are listed in Section 5.1 (Covered Health Services), Section 5.3 (Conditional Coverages), Section 13 (Attachment I – Outpatient Prescription Drugs), and on the MyBind mobile app and MyBind.com website.

Discounts are negotiated with in-network Providers. If you use an in-network Provider, you will pay lower copayments and the Provider will not charge you any additional fees. If you use an out-of-network Provider, you will be responsible for (in addition to your higher out-of-network copayment) all amounts that exceed the Usual and Customary amount.

Once your total copayments (including those for conditional coverages) reach your applicable out-of-pocket maximum, the Bind Plan provides Benefits at 100% of Eligible Charges for the remainder of the Plan Year, except for amounts you pay for out-of-network Covered Health Services in excess of the Usual and Customary amount. These amounts are not counted towards the satisfaction of the out-of-pocket maximums.

## In-Network Benefits

As a Participant in the Bind Plan, you may choose any eligible Provider of health services each time you need to receive a Covered Health Service. The choices you make may affect the amount you pay, as well as the level of Benefits you receive. You will receive the best Benefit from the Bind Plan (and in most instances, your out-of-pocket expenses will be less) when you receive care from in-network Providers. The Bind Plan features a large network of in-network Providers which can be found in the MyBind mobile app or MyBind.com website or call Bind Help for assistance.

These Providers will:

1. File Claims for you.
2. Accept payment based on the discounted rate previously negotiated.

In-network Providers are responsible for obtaining Prior Authorization, Pre-Admission Notification, pre-admission certification for planned inpatient admissions, and/or Emergency admission notification requirements for you. Therefore, it is important that you confirm the Provider's status before you receive services as a Provider's network status may change. For current in-network Provider information, refer to the MyBind mobile app or MyBind.com website or call Bind Help for assistance.

You must show your Bind member identification "ID" card every time you request health care services from an in-network Provider. Your member ID card can be found on the MyBind mobile app; you will also receive an actual member ID card in the mail prior to the Effective Date. If you do not show your member ID card, in-network Providers have no way of knowing that you are enrolled under the Bind Plan. As a result, they may bill you for the entire cost of the services you receive.

Do not assume that an in-network Provider's agreement includes all Covered Health Services. Some in-network Providers contract with Bind to provide only certain Covered Health Services, but not all Covered Health Services. Some in-network Providers choose to be an in-network Provider for only some of our Covered Health Services. Refer to the MyBind mobile app or MyBind.com website or call Bind Help for assistance.

## Out-of-Network Benefits

The Bind Plan generally provides Benefits for medical Claims incurred with an out-of-network Provider at a lower level. As a result, if you choose to seek Covered Health Services outside the network, you will be responsible for the difference between the amount billed by the out-of-network Provider or facility and the amount we determine to be the Eligible Charge for reimbursement. The amount in excess of the Eligible Charge could be significant, and this amount will not apply to the out-of-network out-of-pocket maximum. You may want to ask the out-of-network Provider about their billing practices before you receive care.

Out-of-network Benefits apply to Covered Health Services that are provided by an out-of-network Provider, or Covered Health Services that are provided at an out-of-network facility. If you are using an out-of-network Provider, you are responsible for ensuring that any necessary Prior Authorizations and Pre-Admission Notifications have been obtained, or the services may not be covered by the Bind Plan.

If the Claims Administrator confirms that care is not available from an in-network Provider, the Claims Administrator will work with you to coordinate care through an out-of-network Provider as outlined in the written policy established by the Claims Administrator. Covered Health Services rendered by an out-of-network Provider will be processed at the in-network Benefit level when there are no available in-network Providers. Requests for this Benefit should be made by calling Bind Help at the number on your member ID card **before** you obtain such services.

Out-of-network Providers are not required to file Claims with Bind. If you get Covered Health Services outside of the Bind network and the Provider and/or facility requires that you remit the full amount, contact Bind Help for a Claim form to file a Claim for reimbursement. This may require an itemized bill from the Provider.

Depending on the service you receive and the Provider you receive it from, you may have access to a discount through the network partner's Shared Savings Program for out-of-network Providers. As part of this program, some Providers have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these Providers, the out-of-network copayment will remain the same as for receiving Covered Health Services from out-of- network Providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program Providers than from other out-of-network Providers because the Eligible Expense may be a lesser amount. These discounts are not always known until the service is rendered and cannot be determined in advance.

**Copayments**

A copayment is the amount you pay each time you receive certain Covered Health Services. The table below describes how your coverage works and includes copayments applicable to the Covered Health Services you choose. Some copayments are listed as a range. Bind assigns Provider copayments within the ranges based on the Bind analysis of treatment outcomes and cost information that identifies Physicians, clinics, and hospitals that provide cost-efficient care. **Copayments within the ranges may be updated from time to time, but never higher than the maximum copayment.**

For current Provider-specific copayment information, Participants should check the MyBind mobile app or MyBind.com website or call Bind Help prior to utilizing any services covered under the Bind Plan. The MyBind mobile app and the MyBind.com website will display at least 60 days in advance when a cost for a specific Provider will be moving up or down and the date when the change will occur.

**The full range of copayments displayed may not be available in all geographical areas or for all services. You can find Provider-specific copayment amounts by utilizing the 'Search tool' on the MyBind mobile app or MyBind.com website or call Bind Help.**

You may also be eligible for reduced copayments for certain Benefits and for specific focused programs if you use in-network Providers that Bind has designated as preferred, high-value Providers.

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### Benefit Features

The following chart shows the deductibles and out-of-pocket maximums (limits) for the Bind Plan.

| The Bind Plan | In-Network | Out-of-Network |
|---|---|---|
| **Deductible** | $0 | $0 |
| **Out-of-Pocket Maximum** | | |
| **Individual** | $6,000 | $12,000 |
| **Family** | $12,000 | $24,000 |

**Notes:**

- Refer to the MyBind mobile app for additional coverage notes.
- Once you reach the out-of-pocket maximum, Benefits are payable at 100% of the Eligible Charge during the rest of that year.
- If you have other family members enrolled in the Bind Plan, they have to meet their own individual out-of-pocket maximum until the overall family out-of-pocket maximum has been met. You must pay any amounts greater than the out-of-pocket maximum if any Benefit, day, or visit maximums are exceeded. Expenses you pay for any amount in excess of the Usual and Customary amount will not apply towards satisfaction of the out-of-pocket maximum.
- The amount applied to your in-network out-of-pocket maximum also applies to your out-of-network out-of-pocket maximum. The amount applied to your out-of-network out-of-pocket maximum does not apply to your in-network out-of-pocket maximum.

## 5.1 Covered Health Services

| Ambulance Services | In-Network | Out-of-Network |
|---|---|---|
| | $500 copayment / transport | $500 copayment / transport |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- Ground or air ambulance, as the Claims Administrator determines appropriate.
- Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest hospital that offers Emergency health services.
- Ambulance service by air is covered in an Emergency if ground transportation is impossible or would put your life or health in serious jeopardy. If special circumstances exist, the Claims Administrator may approve Benefits for Emergency air transportation to a hospital that is not the closest facility to provide Emergency health services.
- Ambulance services for non-Emergency: The Bind Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as Bind determines appropriate) between facilities when the transport is:
  - From an out-of-network hospital to an in-network hospital.
  - To a hospital that provides a higher level of care that was not available at the original hospital.
  - To a more cost-effective acute care facility.
  - From an acute care facility to a sub-acute care setting.
- Non-Emergency ground, and air ambulance services may require Prior Authorization and Medical Necessity review.

| Behavioral Health: Mental Health and Substance Use Disorder Services | In-Network | Out-of-Network |
|---|---|---|
| **Mental Health Office Visit (including Telehealth Visit)** | $10 copayment / visit | $120 copayment / visit |
| **Applied Behavioral Analysis (ABA) for Autism Spectrum Disorder Visit** | $10 copayment / visit | $120 copayment / visit |
| **Mental Health Cognitive, Occupational, Physical, and Speech Therapy** | $15 copayment / visit | $40 copayment / visit |
| **Electroconvulsive Therapy (ECT)** | $240 copayment / visit | $480 copayment / visit |
| **Intensive Outpatient Treatment Program (IOP)** | $150 copayment / visit | $300 copayment / visit |
| **Partial Hospitalization (PHP)/Day Treatment** | $240 copayment / day | $480 copayment / day |
| **Subacute Detoxification Care** | $125 copayment / visit | $250 copayment / visit |
| **Substance Use Disorder Medication Therapy** | $15 copayment / visit | $30 copayment / visit |
| **Transcranial Magnetic Stimulation (TMS) Therapy** | $55 copayment / visit | $110 copayment / visit |
| **All Other Outpatient Hospital Services (Visit)** | $1,000 copayment / visit | $2,000 copayment / visit |
| **Residential Treatment Facility Care** | $1,400 copayment / stay | $2,800 copayment / stay |
| **Inpatient Hospital** | $1,500 copayment / stay | $3,000 copayment / stay |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- Benefits include:
  - Diagnostic evaluations, assessment, and treatment planning.
  - Other treatments and/or procedures.
  - Medication management and other associated treatments.
  - Individual, family, and group therapy.
  - Provider-based case management services.
  - Crisis intervention.
  - Intensive Outpatient Treatment program (IOP) (a structured outpatient mental health or substance use treatment program at a freestanding or hospital-based facility and provides services for at least three hours per day, two or more days per week).
  - Residential treatment.
  - Partial hospitalization (PHP)/Day treatment (a structured ambulatory program that may be freestanding or hospital-based and provides services for at least 20 hours per week).
  - Other Outpatient treatment.
- It is important to note that returning home from a visit with durable medical equipment, such as a walker, may result in an additional copayment.
- Mental Health Office Visit refers to a face-to-face visit with your Provider.
- Mental Health Telehealth Visit refers to a non-face-to-face visit with your Provider.
- All inpatient services require Pre-Admission Notification if planned, and notification within 24 hours of admission if emergent.
- Inpatient residential and partial hospitalization services may require Prior Authorization and Medical Necessity review.

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

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

- Intensive Behavioral Therapy (IBT) is outpatient behavioral care services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors, and improve the mastery of functional age-appropriate skills in Participants with Autism Spectrum Disorder.
- 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.
- Visit limits do not apply to therapies provided for a mental health condition, such as autism disorders.
- Applied Behavioral Analysis for Autism Spectrum Disorder services may require Prior Authorization and Medical Necessity review.

| Cancer Chemotherapy | In-Network | Out-of-Network |
|---|---|---|
| | $1,000 copayment / visit | $2,000 copayment / visit |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- Benefits include Physician services and facility charges.
- The Bind Plan provides Benefits for therapeutic treatments received in an office, outpatient hospital, or alternate facility, including intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.
- Covered Health Services include medical education services that are provided in an office, outpatient hospital, or alternate facility by appropriately licensed or registered health care professionals.
- Select Cancer Chemotherapy services may require Prior Authorization and Medical Necessity review.

| Colonoscopy Non-Screening | In-Network | Out-of-Network |
|---|---|---|
| | $425 to $975 copayment / visit | $1,950 copayment / visit |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- Copayments may vary based on Provider and location.
- Benefits include Physician services and facility charges.
- Coverage is available for a non-screening colonoscopy received on an outpatient basis at a hospital, alternate facility, or in a Physician's office.
- When this procedure is performed to diagnose disease symptoms, a copayment applies.
- Services for preventive screenings are provided under the Preventive Care Services section.

| Complex Imaging | In-Network | Out-of-Network |
|---|---|---|
| | $200 to $700 copayment / visit | $1,400 copayment / visit |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- Copayments may vary based on Provider and location.
- Benefits include Physician services and facility charges.
- Coverage includes MRI (Magnetic Resonance Imaging), MRA (Magnetic Resonance Angiography), CT (Computed Tomography), PET (Positron Emission Tomography), and Nuclear Medicine.
- If imaging occurs on multiple areas of the body at the same visit, such as the lumbar spine and the cervical spine, one copayment will apply.
- If your Physician suggests a low-dose CT Scan (LDCT) for lung cancer screening, refer to Preventive Care Services, in this section, for coverage notes.

| Dental Services: Accidental and Medical | In-Network | Out-of-Network |
|---|---|---|
| **Office Visit** | $10 to $85 copayment / visit | $160 copayment / visit |
| **All Other Services:** | | |
| • **Outpatient Hospital Visit** | $1,000 copayment / visit | $2,000 copayment / visit |
| • **Inpatient Hospital** | $1,500 copayment / stay | $3,000 copayment / stay |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- Copayments for office visits may vary based on Provider and location.
- It is important to note that returning home from a visit with durable medical equipment, such as an oral appliance, may result in an additional copayment.
- The Bind Plan provides Benefits for dental services to treat and restore damage done to a sound, natural tooth as a result of an accidental injury. Coverage is for external trauma to the face and mouth only. A sound, natural tooth is a tooth, including supporting structures, that is healthy and would be able to continue functioning for at least one year. Primary (baby) teeth must have a life expectancy of one year before loss. Treatment and repair for services required due to an accidental injury must be started within three months and completed within twelve months of the date of the injury.
- Benefits are provided for the following limited oral surgical procedures determined to be Medically Necessary and appropriate:
  - Oral surgery and anesthesia for removal of a tooth root without removal of the whole tooth, and root canal therapy.
  - Mandibular staple implant provided the procedure is not done to prepare the mouth for dentures.
  - Facility Provider and anesthesia services rendered in a Provider facility setting in conjunction with non-covered dental procedures when determined by the Claims Administrator to be Medically Necessary and appropriate due to your age and/or medical condition.
  - The correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof, and floor of the mouth.
- The Bind Plan also covers dental services, limited to dental services required for treatment of an underlying medical condition such as a cleft palate or other congenital defect, oral reconstruction after invasive oral tumor removal, preparation for or as a result of radiation therapy for oral or facial cancer.
- Eligible Charges for hospitalizations are those incurred by a Participant who: (1) is a child under age five; (2) is severely disabled; or (3) has a medical condition, unrelated to the dental procedure that requires hospitalization or anesthesia for dental treatment. Coverage is limited to facility and anesthesia charges. Oral surgeon/dentist or dental Specialist professional fees are not covered for dental services provided. The following are examples, though not all-inclusive, of medical conditions that may require hospitalization for dental services: severe asthma, severe airway obstruction, or hemophilia. Care must be directed by a Physician, dentist, or dental Specialist.
- Accidental Dental Services may require Prior Authorization and Medical Necessity review.

| Dialysis Services | In-Network | Out-of-Network |
|---|---|---|
| **Office Visit** | $10 to $85 copayment / visit | $160 copayment / visit |
| **Outpatient Hospital Visit** | $1,000 copayment / visit | $2,000 copayment / visit |
| **Inpatient Hospital** | $1,500 copayment / stay | $3,000 copayment / stay |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- Copayments for office visits may vary based on Provider and location.
- The Bind Plan provides Benefits for therapeutic treatments received in an office, home, outpatient hospital, or alternate facility.
- Benefit includes services and supplies for renal dialysis, including both hemodialysis and peritoneal dialysis.
- Benefit also includes training of the patient.

| Durable Medical Equipment (DME) and Supplies | In-Network | Out-of-Network |
|---|---|---|
| **Tier 1** | $0 copayment | $20 copayment |
| **Tier 2** | $20 copayment | $40 copayment |
| **Tier 3** | $40 copayment | $80 copayment |
| **Tier 4** | $60 copayment | $120 copayment |
| **Tier 5** | $80 copayment | $160 copayment |
| **Tier 6** | $100 copayment | $200 copayment |
| **Tier 7** | $150 copayment | $300 copayment |
| **Tier 8** | $200 copayment | $400 copayment |
| **Tier 9** | $250 copayment | $500 copayment |
| **Tier 10** | $350 copayment | $700 copayment |
| **Tier 11** | $500 copayment | $1,000 copayment |
| **Tier 12** | $1,000 copayment | $2,000 copayment |

**Notes:**

- Durable Medical Equipment (DME) and supplies are tiered based on average cost and allowed amount. Supplies such as tubing, syringes, and catheters are assigned to a lower tier and will result in a lower copayment. Equipment such as glucose monitors, pumps, and wheelchairs are assigned to a higher tier and will result in a higher copayment.
- Each piece of durable medical equipment and supplies are assigned to a tier, which corresponds to a copayment. A breakdown of the tiers and corresponding copayments can be found on MyBind mobile app or MyBind.com website.
- It is important to note that returning home from an appointment with a health care Provider or from the hospital with durable medical equipment, such as crutches, may result in an additional copayment. Copayments will be dependent on the tier the item falls into.

The Bind Plan provides Benefits for durable medical equipment, prosthetics, orthotics, and supplies subject to the limitations listed below:

- Refer to the MyBind mobile app for additional coverage and copayment information.
- This durable medical equipment and supplies list is subject to periodic review and modification (generally quarterly, but no more than six times per calendar year).
- You may also view which tier a particular DME item has been assigned to by using the MyBind mobile app or MyBind.com website or call Bind Help for assistance.
- Coverage includes rental or purchase of DME if Medically Necessary, ordered or provided by a Physician for outpatient use primarily in a home setting, serves a medical purpose for the treatment of an illness or injury, and is not of use to a Participant in the absence of a disease or disability. If you need certain durable medical equipment for an extended period of time, there may be an option to rent. The copayment you see based on tier will be split over a 10-month period, at which point the DME may be considered “purchased” or coverage will end. Note that some equipment such as oxygen equipment, will be set to rental for the duration of time the equipment is needed, which may extend well beyond 10 months.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors, and masks).
- Cranial orthoses such as head shaping helmets and head reconstruction are a set of orthotic devices and services to reshape the head. They may be medically indicated for plagiocephaly (head asymmetry) and craniosynostosis (abnormal head shape).
- Scalp/cranial hair prostheses (wigs) are a Covered Health Service for scalp/head wound, burns, injuries, alopecia areata, cancer, and undergoing chemotherapy or radiation therapy and are limited to a maximum Benefit of $350 per Plan Year for in-network and out-of-network Providers combined.
- Cataract surgery or aphakia is limited to one frame and one pair of lenses or one pair of contact lenses or a one-year supply of disposable contact lenses.

- Hearing aids are limited to $3,000 maximum benefit every three years through UnitedHealthcare Hearing only. Participants can use their hearing benefit by visiting uhchearing.com or calling UnitedHealthcare Hearing at 1-866-334-4425, TTY 711.
- Purchase of one standard breast pump, either manual or electric, per pregnancy or postpartum Participants per pregnancy. Participant may have to pay a surcharge to the Provider if they purchase enhanced models.
- Enteral Nutrition and low protein modified food products administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. The formula or product must be administered under the direction of a Physician or registered dietitian. (example conditions include, but are not limited to, metabolic disease such as phenylketonuria (PKU) and maple syrup urine disease severe food allergies, and impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract).
- Shoes as prescribed by a Provider for a Participant with diabetic foot disease. Limited to one pair per calendar year.
- Coverage is provided for eligible durable medical equipment that meets the minimum medically appropriate equipment standards needed for the patient's medical condition.
- Select Durable Medical Equipment (DME) may require Prior Authorization and Medical Necessity review.

| Emergency Room Services | In-Network | Out-of-Network |
|---|---|---|
| **Emergency Room Visit** | $400 copayment / visit | $400 copayment / visit |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- Copayment applies to Emergency room facility, professional expenses, and includes related expenses.
- It is important to note that returning home from an Emergency Room visit or hospital with durable medical equipment, such as crutches, may result in an additional copayment.
- If you are admitted as an inpatient directly from the Emergency room for the same condition, the Emergency room services copayment will be waived, and you will be responsible for Inpatient Hospital Services copayment.
- If you are admitted to observation directly from the Emergency room for the same condition, the Emergency room services copayment will be waived, and you will be responsible for the Outpatient Hospital Services copayment.
- Refer to Hospital Services section for additional coverage notes.

| Gender Dysphoria Services | In-Network | Out-of-Network |
|---|---|---|
| **Mental Health Office Visit** | $10 copayment / visit | $120 copayment / visit |
| **Outpatient Hospital Visit** | $1,000 copayment / visit | $2,000 copayment / visit |
| **Inpatient Hospital** | $1,500 copayment / stay | $3,000 copayment / stay |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.

The following services are covered for gender dysphoria:

- Surgery for the treatment for gender dysphoria, including the surgeries listed below:
  - **Male to Female**: Clitoroplasty (creation of clitoris). Labiaplasty (creation of labia), Orchiectomy (removal of testicles), Penectomy (removal of penis), Urethroplasty (genital reconstruction of female urethra), Vaginoplasty (creation of vagina).
  - **Female to Male**: Bilateral mastectomy or breast reduction, Hysterectomy (removal of uterus), Metoidioplasty (creation of penis, using clitoris), Penile prosthesis, Phalloplasty (creation of penis), Salpingo-oophorectomy (removal of fallopian tubes and ovaries), Scrotoplasty (creation of scrotum), Testicular prosthesis, Urethroplasty (reconstruction of male urethra), Vaginectomy (removal of vagina). à Vulvectomy (removal of vulva).
- Select services for the treatment of Gender Dysphoria may require Prior Authorization and Medical Necessity review.

**Gender Dysphoria:** A disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association.*

- **Diagnostic criteria for adults and adolescents:** A marked incongruence between one's experienced/expressed gender and assigned gender at birth, of at least six months' duration, as manifested by at least two of the following:
  - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
  - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
  - A strong desire for the primary and/or secondary sex characteristics of the other gender.
  - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender at birth).
  - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender at birth).
  - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender at birth).
  - The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- **Diagnostic criteria for children:** A marked incongruence between one's experienced/expressed gender and assigned gender at birth, of at least six months' duration, as manifested by at least six of the following (one of which must include the criterion as shown in the first bullet below):
  - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender at birth).
  - In boys (assigned gender at birth), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender at birth), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
  - A strong preference for cross-gender roles in make-believe play or fantasy play.
  - A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
  - A strong preference for playmates of the other gender.
  - In boys (assigned gender at birth), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender at birth), a strong rejection of typically feminine toys, games, and activities.
  - A strong dislike of ones' sexual anatomy.
  - A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
  - The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

| Genetic Testing | In-Network | Out-of-Network |
|---|---|---|
| | $160 copayment / visit | $320 copayment / visit |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- The following categories of services are covered:
  - Genetic tests for cancer susceptibility.
  - Genetic tests for hereditary diseases.
  - Unspecified molecular pathology.
  - Fetal aneuploidy testing.
- Select Genetic Testing services may require Prior Authorization and Medical Necessity review.

| Home Health Services | In-Network | Out-of-Network |
|---|---|---|
| **Home Health Care Visit** | $25 copayment / visit | $160 copayment / visit |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- Limited to 60 visits per Participant per Plan Year for in-network and out-of-network Providers combined.
- Services received from a Home Health Agency (an organization authorized by law to provide health care services in the home) or independent Provider that are the following:
- Ordered by a Physician.
- Provided in your home by a registered nurse or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Provided on a part-time, intermittent care schedule.
- Provided when skilled care is required.
- Occupational therapy, physical therapy, and/or speech therapy visits performed in the home, billed by the Home Health Agency, will apply to the Home Health Services visit limits.
- Occupational therapy, physical therapy, and/or speech therapy visits performed in the home, not administered by a Home Health Agency will apply to the Rehabilitative/Habilitative Services visit limits.
- Select Home Health Services may require Prior Authorization and Medical Necessity review.
- Prior authorization required 5 days before receipt of services. Without Prior Authorization services are not covered.

| Hospice Care | In-Network | Out-of-Network |
|---|---|---|
| **Home Hospice Visit** | $25 copayment / visit | $160 copayment / visit |
| **Inpatient Hospital** | $1,500 copayment / stay | $3,000 copayment / stay |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill.
- Hospice care can be provided in the home or an inpatient setting and includes physical, psychological, social, spiritual, and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Participant (terminally ill person) is receiving hospice care.
- Benefits are available only when hospice care is received from a licensed hospice agency, which can include a hospital.
- Inpatient Hospice Care may require Prior Authorization and Medical Necessity review.

| Hospital Services | In-Network | Out-of-Network |
|---|---|---|
| **Outpatient Hospital Visit** | $1,000 copayment / visit | $2,000 copayment / visit |
| **Inpatient Hospital** | $1,500 copayment / stay | $3,000 copayment / stay |

**Notes:**

- Hospital Services: The above copayments apply for Covered Health Services not specifically listed in this SPD, MyBind mobile app or MyBind.com website.
- Refer to the MyBind mobile app for additional coverage information.
- Multiple copayments may apply if more than one treatment or procedure is performed during a visit/stay.
- Outpatient Hospital Visit copayment will apply for an Observation Stay.
- Inpatient hospitalization/stay Benefits include:
  - Physician and non-Physician services, supplies, and medications received during an inpatient stay.
  - Facility charges, including room and board in a semi-private room (a room with two or more beds).
  - Physician services for lab tests, anesthesiologists, pathologists, radiologists, and Emergency room Physicians.
  - The Bind Plan will allow the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice.

- If you are admitted to inpatient from the Emergency department or from observation, the Emergency room copayment or observation copayment will be waived.
- It is important to note that returning home from an outpatient visit or hospital with durable medical equipment, such as crutches, may result in an additional copayment.
- All inpatient services require Pre-Admission Notification if planned, and notification within 24 hours of admission if emergent.

| Laboratory Services, X-Rays, and Diagnostic Tests - Outpatient | In-Network | Out-of-Network |
|---|---|---|
| **Non-Routine Diagnostic Laboratory Services / X-Rays / Ultrasounds** | $50 to $300 copayment / visit | $170 to $600 copayment / visit |
| **Routine Diagnostic Laboratory Services / X-Rays / Ultrasounds** | $0 copayment / visit | $0 copayment / visit |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information and the copayment that has been assigned to your procedure/service.
- Copayments for Non-Routine Diagnostic Laboratory Services/X-ray/Ultrasounds may vary based on Provider, location, and procedure.
- Non-Routine diagnostic tests or scopes such as Upper GI Endoscopy require a Participant to elect and activate coverage prior to receiving service. Please see Section 5.3 (Conditional Coverages) and Section 2 (How Does the Bind Personalized Health Plan Work) for additional information and the full list of coverages that require you to elect and activate coverage.
- Services for illness and injury-related diagnostic purposes, received on an outpatient basis at a hospital, alternate facility, or in a Physician's office include:
  - Non-routine diagnostic testing including, but not limited to:
    - Echocardiogram Exercise Stress Test.
    - EKG Exercise Stress Test.
    - Electroencephalogram (EEG).
    - Electromyography (EMG) and Nerve Conduction Studies (NCS).
    - Sleep Study.
    - Transthoracic Echocardiogram (TTE).
  - Routine diagnostic testing such as:
    - Diagnostic labs, pathology tests, and interpretation charges, such as blood tests, analysis of tissues, or liquids from the body.
    - Diagnostic ultrasounds and X-rays, such as fluoroscopic tests and interpretation.
- Select Laboratory services and Diagnostic Testing may require Prior Authorization and Medical Necessity review.

| Maternity Care and Delivery | In-Network | Out-of-Network |
|---|---|---|
| **Routine Prenatal and Postnatal Office Visits including Labs and Tests** | $0 copayment / visit | $120 copayment / visit |
| **Inpatient Delivery** | $500 to $1,500 copayment / stay | $3,000 copayment / stay |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- The copayments for inpatient delivery may vary based on Provider and location; this includes a birthing center.
- It is important to note that returning home from an outpatient visit or hospital with durable medical equipment, such as a fetal monitor, may result in an additional copayment.
- Routine prenatal and postnatal maternity services include evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force and Health Resources and Services Administration.
- Home visit limited to one visit immediately following discharge of mother and newborn.

- Hospital visits or admissions that do not result in delivery including false labor and tests or services not considered "routine" will follow the inpatient or outpatient hospital services Benefit.
- There will be one copayment for all Covered Health Services related to childbirth/delivery, including the newborn, unless discharged after the mother. If a newborn baby is discharged after the mother, another copayment will apply to the baby's services. See Hospital Services section for Benefits.
- Inpatient deliveries do not require Prior Authorization or notification unless the mother is hospitalized more than 48-hours following a normal vaginal delivery and 96-hours following a normal cesarean section delivery. Stays beyond these time periods may require Prior Authorization and Medical Necessity review.

| Medical Infusions and Injectables | In-Network | Out-of-Network |
|---|---|---|
| **Office / Home – Tier 1** | $325 copayment / visit | $650 copayment / visit |
| **Outpatient Hospital - Tier 1** | $975 copayment / visit | $1,950 copayment / visit |
| **Office / Home – Tier 2** | $625 copayment / visit | $1,250 copayment / visit |
| **Outpatient Hospital– Tier 2** | $1,200 copayment / visit | $2,400 copayment / visit |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information and for the copayment assigned to your procedure/service.
- Benefits are available for certain medical infusions and injectables administered on an outpatient basis in a hospital facility, alternate facility, in a Physician's office, or in the home.
- The Medical Infusions and injectables require supervision and follow up with a medical professional. The Tier 1 and Tier 2 drugs will be dispensed and administered by a medical professional. Tier 1 drugs are dispensed by a medical professional and may require special handling and storage. Tier 2 drugs may require special handling and storage and are generally considered Specialty Drugs administered by a medical professional.
- This copayment applies to specific drugs that must be administered in a medical setting or under medical supervision. Call Bind Help to learn which infusions and injections are subject to these copayments.
- See the Cancer Chemotherapy section for coverage notes related to Cancer Chemotherapy administration.
- Select injectable drugs that can be safely self-administered may not be covered under the medical Benefit. These drugs or equivalent drugs are covered under the pharmacy Benefits (see Section 13, Attachment I – Outpatient Prescription Drugs).
- Select Medical Infusions and Injectables may require Prior Authorization and Medical Necessity review.

| Office Visit and Diagnostic Visit | In-Network | Out-of-Network |
|---|---|---|
| **Office Visit (including Telehealth Visit)** | $10 to $85 copayment / visit | $160 copayment / visit |
| **Mental Health Office Visit (including Telehealth Visit)** | $10 copayment / visit | $120 copayment / visit |
| **The Well** | $0 copayment / visit | N/A |
| **Allergy Injection Visit** | $0 copayment / visit | $120 copayment / visit |
| **Allergy Testing and Treatment** | $80 copayment / visit | $160 copayment / visit |
| **Convenience Care / Retail visit** | $20 copayment / visit | Not Covered |
| **E-Visit and Telephone Consult with Your Physician after an Emergency Room Visit** | $25 copayment / visit | Not Covered |
| **Provider House Call (Home Visit)** | $50 copayment / visit | Not Covered |
| **Virtual Visit – other than Designated Provider (see Virtual Visit*)** | See Virtual Visit section for details | Not Applicable |

**Notes:**

The Bind Plan provides Benefits for services provided in an office for the diagnosis and treatment of an illness or injury.

- Refer to the MyBind mobile app for additional coverage information.
- Copayments for office visits may vary based on Provider and location.
- Office Visit refers to face-to-face visit or Telehealth visit with your Provider.

- Multiple copayments may apply if a treatment or procedure is also performed during a visit.
- Mental Health Office Visit refers to a face-to-face visit with your Provider.
- Mental Health Telehealth Visit refers to a non-face-to-face visit with your Provider.
- Virtual Visit refers to a visit with a Designated Virtual Provider such as Doctor on Demand. See Virtual Visit Section for details.
- Convenience Care/Retail Clinics are walk-in clinics in retail stores, supermarkets, and pharmacies that treat uncomplicated minor illnesses and injuries, and provide preventive care services.
- *See Virtual Visit section for virtual visit details.
- If your Provider refers you for a test or service within a hospital or other facility, the Outpatient Hospital copayment may apply.
- It is important to note that returning home from a visit with durable medical equipment, such as crutches, may result in an additional copayment.

| **Orthognathic Surgery and Temporomandibular Joint (TMJ) Disorder** | **In-Network** | **Out-of-Network** |
|---|---|---|
| **Orthognathic (Jaw) Surgery** | $1,850 copayment / visit | $3,700 copayment / visit |
| **Temporomandibular Joint (TMJ) Dysfunction Surgery** | $1,250 copayment / visit | $2,500 copayment / visit |
| **All other services:** | | |
| • **Office Visit** | $10 to $85 copayment / visit | $160 copayment / visit |
| • **Outpatient Hospital Visit** | $1,000 copayment / visit | $2,000 copayment / visit |
| • **Inpatient Hospital** | $1,500 copayment / stay | $3,000 copayment / stay |

**Notes:**

The Bind Plan provides Benefits for services for the evaluation and treatment of TMJ and associated muscles.

- Refer to the MyBind mobile app for additional coverage information.
- Copayments for office visits may vary based on Provider and location.
- Includes orthodontic services and supplies, and surgical and non-surgical options for the treatment of TMJ. Benefits for surgical services also include FDA-approved TMJ prosthetic replacements when all other treatments have failed.
- It is important to note that returning home from a visit with durable medical equipment, such as an oral appliance, may result in an additional copayment.
- Orthognathic surgery may require Prior Authorization and Medical Necessity review.

| **Palliative Care** | **In-Network** | **Out-of-Network** |
|---|---|---|
| **Office Visit** | $10 to $85 copayment / visit | $160 copayment / visit |
| **Home Care Visit** | $25 copayment / visit | $160 copayment / visit |
| **Outpatient Hospital Visit** | $1,000 copayment / visit | $2,000 copayment / visit |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- Copayments for office visits may vary based on Provider and location.
- The Bind Plan provides Benefits for palliative care for Participants with a new or established diagnosis of progressive debilitating illness.
- Includes services for pain management received as part of a palliative care treatment plan.
- The services must be within the scope of the Provider's license to be covered.
- Select services performed in the office and outpatient hospital setting may require Prior Authorization and Medical Necessity Review.
- It is important to note that returning home from a visit with durable medical equipment, such as a walker, may result in an additional copayment.
- See Hospice Care notes for services related to Hospice.

| Prescription Drugs | In-Network | Out-of-Network |
|---|---|---|
| | See Section 13, Attachment I – Outpatient Prescription Drugs for details | Not Covered |

| Preventive Care Services | In-Network | Out-of-Network |
|---|---|---|
| | $0 copayment / visit | $120 copayment / visit |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- Services include evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, Bright Futures, Health Resources and Services Administration, and Advisory Committee on Immunization Practices.
- Examples include:
  - Pediatric preventive care services, developmental assessments, and laboratory services appropriate to the age of a child from birth to age six, and appropriate immunizations up to age 18.
  - Coverage includes at least five child health supervision visits from birth to 12 months, three child health supervision visits from 12 months to 24 months, and once-a-year visits from 24 months to age six.
  - Routine physical exams.
  - Routine screenings for certain cancers and other conditions, such as colonoscopies and mammograms.
  - Routine screening colonoscopy and mammograms are covered as preventive with a diagnosis of family history.
  - Routine immunizations.
  - Routine lab tests, pathology, and radiology.
  - Hearing and vision screening limited to one exam per calendar year for children up to age of 21.
  - Routine prenatal services.
  - One routine postnatal care exam provided during the period immediately after childbirth that includes a health exam, assessment, education, and counseling.
  - Preventive contraceptive methods and counseling for women.
    - Includes certain approved contraceptive methods for women with reproductive capacity, including contraceptive drugs, devices, and delivery methods.
- For Prescription Drug Coverage see Section 13 (Attachment I – Outpatient Prescription Drugs).
- Low-dose CT Scan (LDCT) for lung cancer screening may require Prior Authorization and Medical Necessity review.

| Radiation Therapy and Other High Intensity Therapy | In-Network | Out-of-Network |
|---|---|---|
| | $300 to $950 copayment / visit | $600 to $1,900 copayment / visit |

**Notes:**

- The Bind Plan provides Benefits for services received on an outpatient basis at a hospital, alternate facility, or in a Physician's office.
- Refer to the MyBind mobile app for additional coverage information and the copayment assigned to your procedure/service.
- Benefits include Physician services and facility charges, and services such as, but not limited to:
  - Brachytherapy.
  - Conventional External Beam Radiation Therapy (EBRT).
  - Proton Therapy.
  - Radiation Therapy Simulation and Planning.
  - Stereotactic Radiation Therapy.
- Select Radiation Therapies may require Prior Authorization and Medical Necessity Review.

| Reconstructive Surgery | In-Network | Out-of-Network |
|---|---|---|
| **Office Visit** | $10 to $85 copayment / visit | $160 copayment / visit |
| **Outpatient Hospital** | $1,000 copayment / visit | $2,000 copayment / visit |
| **Inpatient Hospital** | $1,500 copayment / stay | $3,000 copayment / stay |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- Copayments for office visits may vary based on Provider and location.
- Multiple copayments may apply if more than one treatment or procedure is performed during a visit/stay.
- It is important to note that returning home from an outpatient visit or hospital with durable medical equipment, such as a walker, may result in an additional copayment.
- Reconstructive procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive procedures include surgery or other procedures which are associated with an illness, injury, or congenital anomaly. The primary result of the procedure is not a changed or improved physical appearance.
- Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.
- Benefits for Reconstructive procedures include breast reconstruction following a mastectomy and Reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Bind Plan if the initial breast implant followed a mastectomy. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Services. You can contact Bind Help at the number on your member ID card for more information about Benefits for mastectomy-related services.
- There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Procedures that correct an anatomical congenital anomaly without improving or restoring physiologic function are considered Cosmetic procedures. An example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive procedure. In other cases, if improvement in appearance is the primary intended purpose, this would be considered a Cosmetic procedure. The Bind Plan does not provide Benefits for Cosmetic services or procedures.
- The fact that a Participant may suffer psychological consequences or socially avoidant behavior as a result of an illness, injury, or congenital anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as Reconstructive procedures.
- Reconstructive Surgery may require Prior Authorization and Medical Necessity review.

| Rehabilitative/Habilitative Services and Other Low Intensity Therapy | In-Network | Out-of-Network |
|---|---|---|
| **Acupuncture Visit** | $25 copayment / visit | $50 copayment / visit |
| **Aural Therapy – Post Cochlear Implant** | $10 to $85 copayment / visit | $160 copayment / visit |
| **Cardiac Rehabilitation Therapy** | $40 copayment / visit | $80 copayment / visit |
| **Chiropractic Visit** | $25 copayment / visit | $50 copayment / visit |
| **Cognitive, Occupational, Physical, and Speech Therapy Visit** | $15 to $35 copayment / visit | $90 copayment / visit |
| **Pulmonary Rehabilitation Therapy** | $40 copayment / visit | $80 copayment / visit |

**Notes:**

Rehabilitative and habilitative services must be performed by a Physician or by a licensed therapy Provider. Benefits includes services provided in a Physician's office or on an outpatient basis at a hospital, or alternate facility. Services provided in your home are provided as described under the Home Health Care section.

- Refer to the MyBind mobile app for additional coverage and copayment information.
- The copayments for certain therapies may vary based on Provider and location (e.g., aural, cognitive, occupational, physical, and speech therapy).
- It is important to note that returning home from a visit with durable medical equipment, such as a walker, may result in an additional copayment.
- Acupuncture is limited to 10 visits or services per Participant per Plan Year for in-network and out-of-network Providers combined.
- Aural Therapy does not have visit limits.
- Cardiac Rehabilitation is limited to 36 visits per Participant per Plan Year for in-network and out-of-network Providers combined.
- Chiropractic Visits are limited to 20 visits or services, per Participant per Plan Year for in-network and out-of-network Providers combined.
  - **Manipulative Treatment:** The therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.
- Occupational, cognitive, and physical therapy visits are limited to 60 visits combined per Participant per Plan Year for in-network and out-of-network Providers combined.
  - Cognitive rehabilitation therapy following traumatic brain Injury or cerebral vascular accident is covered when Medically Necessary.
- Pulmonary Rehabilitation is limited to 20 visits per Participant per Plan Year for in-network and out-of-network Providers combined.
- Speech therapy is limited to 90 visits per Participant per Plan Year for in-network and out-of-network Providers combined.
- Therapies provided in the home will be assigned the home health care visit copayment. See Home Health Services for coverage notes.
- Therapies related to the treatment of a mental health condition, such as autism disorder, are provided under Behavioral Health – Mental Health and Substance Use Disorder services section and do not apply to limits in this section.

| Skilled Nursing / Rehab Facility Services | In-Network | Out-of-Network |
|---|---|---|
| **Skilled Nursing Facility** | $1,400 copayment / stay | $2,800 copayment / stay |
| **Inpatient Rehabilitation Facility** | $1,400 copayment / stay | $2,800 copayment / stay |

**Notes:**

The Bind Plan provides Benefits for services provided during an inpatient stay in a Skilled Nursing Facility or inpatient rehabilitation facility.

- Skilled Nursing Facility stays are limited to 120 days per Participant per Plan Year for in-network and out-of-network Providers combined.
- Inpatient Rehabilitation Facility stays are limited to 120 days per Participant per Plan Year for in-network and out-of-network Providers combined.
- An Inpatient Rehabilitation Facility, such as a long-term acute rehabilitation center, a hospital, or a special unit of a hospital designated as an inpatient rehabilitation facility, that provides occupational therapy, physical therapy, and/or speech therapy as authorized by law.
- Benefits include:
  - Facility services for an inpatient stay in a Skilled Nursing Facility or inpatient rehabilitation facility.
  - Supplies and non-Physician services received during the inpatient stay.
  - Room and board in a semi-private room (a room with two or more beds).
  - Physician services for anesthesiologists, pathologists, and radiologists.
  - Benefits are available when skilled nursing and/or inpatient rehabilitation facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or inpatient rehabilitation facility for treatment of an illness or injury that would have otherwise required an inpatient stay in a hospital.

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- Benefits are available only if both of the following are true:
  - The initial confinement in a Skilled Nursing Facility or inpatient rehabilitation facility was or will be a cost-effective alternative to an inpatient stay in a hospital.
  - You will receive skilled care services that are not primarily Custodial Care.
- Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:
  - Services must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
  - Services are ordered by a Physician.
  - Services are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing, or transferring from a bed to a chair.
  - Services require clinical training in order to be delivered safely and effectively.
- You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Participants who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.
- The Bind Plan does not provide Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 12 (Glossary).
- It is important to note that returning home from a Skilled Nursing Facility or Inpatient Rehabilitation Facility stay with durable medical equipment, such as a walker, may result in an additional copayment.
- All Skilled Nursing Facility and Inpatient Rehabilitation Facility admissions require Prior Authorization and Medical Necessity review.
- See Hospital Services for other coverage notes.

| Transplant Services | In-Network | Out-of-Network |
|---|---|---|
| **Bone Marrow and Solid Organ Transplant** | $2,600 copayment / visit | Not Covered |
| **Corneal Transplant** | $1,450 copayment / visit | Not Covered |
| **Cellular and Gene Therapy:** | | |
| • **Outpatient Hospital Visit** | $1,000 copayment / visit | Not Covered |
| • **Inpatient Hospital** | $1,500 copayment / stay | Not Covered |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- Transplants for which Benefits are available include bone marrow (including CAR T-cell therapy for malignancies), heart, heart/lung, lung, kidney, kidney/pancreas, pancreas, liver, liver/intestine, intestine, and cornea.
- Benefits are also available for cellular and gene therapy received on an inpatient or outpatient basis at a hospital or on an outpatient basis at an alternate facility.
- Bind has identified quality Providers for transplant services (except for corneal transplant) referred to as the Transplant Centers of Excellence, see Section 5.5 (Clinical Programs) for additional information. Transplant services (except for corneal transplant) must be rendered at a location specified as a Center of Excellence.
- All Participants undergoing transplant services (except for corneal transplant) must enroll in Transplant Resource Services, which is a care coordination program for patients undergoing transplants.
- Benefits are available to the donor and the recipient when the recipient is covered under the Bind Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage.
- Bind has specific guidelines regarding Benefits for transplant services. Contact Bind Help at the number on your member ID card for information about these guidelines.
- The Bind Plan provides Benefits for expenses for travel and lodging for the patient, and a companion up to a maximum of $10,000 per lifetime per Participant, 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 an in-network Provider for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
  - Eligible Expenses include lodging for the patient (while not a hospital inpatient) and one companion.
  - If the patient is an enrolled dependent minor child, the transportation expenses of two companions will be covered.
  - Travel and lodging expenses are only available if the patient resides more than 50 miles from the in-network Provider.
  - Reimbursement for certain lodging expenses for the patient and his/her companion(s) may be included in the taxable income of the Participant if the reimbursement exceeds the per diem rate.
- The Claims Administrator must receive valid receipts for such charges before you will be reimbursed.
- Transplant Services may be subject to Prior Authorization and Medical Necessity Review.

**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.
  - Per diem is limited to $100 per day for the patient and one caregiver. When a child is the patient, two persons may accompany the child.
- **Travel:**
  - Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the in-network Provider.
  - Taxi fares (not including limos or car services).
  - Economy or coach airfare.
  - Parking.
  - Trains.
  - Boat.
  - Bus.
  - Tolls.
- **Examples of items that are not covered:**
  - Groceries.
  - Alcoholic beverages.
  - Personal or cleaning supplies.
  - Meals.
  - Over-the-counter dressings or medical supplies.
  - Deposits.
  - Utilities and furniture rental, when billed separate from the rent payment.
  - Phone calls, newspapers, or movie rentals.

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| Treatment / Tests / Therapies – Go to MyBind mobile app or MyBind.com website for additional information | In-Network | Out-of-Network |
|---|---|---|
| • **Tier 1:** Generally, minor procedures or treatments that are typically performed in an outpatient office setting (e.g., eye cryotherapy, capsule endoscopy, etc.) | $70 to $510 copayment / visit | $140 to $1,020 copayment / visit |
| • **Tier 2:** Generally, minor procedures, surgeries, or treatments that are typically performed in an outpatient hospital setting (e.g., bronchoscopy, needle biopsy and aspiration, etc.) | $350 to $1,250 copayment / visit | $1,300 to $2,500 copayment / visit |
| • **Tier 3:** Generally, major procedures, surgeries, or treatments that are typically performed in an outpatient hospital setting but may be performed in an inpatient hospital setting (e.g., thyroid surgery, parathyroid surgery, etc.) | $800 to $2,200 copayment / visit/stay | $3,500 to $4,400 copayment / visit/stay |
| • **Tier 4:** Generally, major procedures, surgeries, or treatments that are typically performed in an inpatient hospital but may be performed in an outpatient hospital setting (e.g., colon surgery, small bowel surgery, etc.) | $850 to $2,350 copayment / visit/stay | $4,200 to $4,700 copayment / visit/stay |
| **Other Treatments/Tests/Therapies:** refer to the MyBind mobile app or MyBind.com website for coverage and copayment information or call Bind Help. Copayments may vary based on Provider, location and treatment, test, or therapy. | | |
| • **Office Visits** | $10 to $85 copayment / visit | $160 copayment / visit |
| • **Outpatient Hospital Visit** | $1,000 copayment / visit | $2,000 copayment / visit |
| • **Inpatient Hospital** | $1,500 copayment / stay | $3,000 copayment / stay |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information and for the copayment assigned to your procedure/service.
- The copayments above apply unless a Benefit is specified in another section of this SPD, MyBind mobile app or MyBind.com website.
- Treatment, tests, and therapies have been tiered based on type and level (minor vs. major) of care. Some minor treatments or procedures are either included in the office visit copayment or may have a specific copayment based on the Provider and location selected. Some surgical procedures also have specific copayments based on the Provider or location selected.
- Multiple copayments may apply if more than one treatment or procedure is performed during a visit/stay.
- Copayments for Procedures in Tier 1 - Tier 4 may vary based on Provider and location. Refer to the MyBind mobile app, or call Bind Help to determine the copayment assigned to your procedure/service.
  - Tier 1 is a category of minor procedures typically performed in an outpatient office setting.
  - Tier 2 is a category of minor surgeries and procedures or services typically performed in an outpatient hospital setting.
  - Tier 3 is a category of major surgeries and procedures typically performed in an outpatient hospital setting.
  - Tier 4 is a category of major surgeries typically performed in an inpatient hospital setting.
- An Observation Stay is considered as an outpatient hospital visit.
- Inpatient hospitalization/stay Benefits include:
  - Physician and non-Physician services, supplies, and medications received during an inpatient stay.
  - Facility charges, including room and board in a semi-private room (a room with two or more beds).
  - Physician services for lab tests, anesthesiologists, pathologists, radiologists, and Emergency room Physicians.

- The Bind Plan will allow the difference in cost between a semi-private room and a private room only if a private room is necessary according to generally accepted medical practice.
- If you are admitted to inpatient from the Emergency department or from observation, the Emergency room copayment or observation copayment will be waived.
- It is important to note that returning home from an outpatient visit or hospital with durable medical equipment, such as a walker, may result in an additional copayment.
- All inpatient services require Pre-Admission Notification if planned, and notification within 24 hours of admission if emergent.
- Select office-based and outpatient procedures may require Prior Authorization and Medical Necessity review.

| Urgent Care | In-Network | Out-of-Network |
|---|---|---|
| **Urgent Care Visit** | $150 copayment / visit | $300 copayment / visit |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- Benefits include visits at a walk-in Urgent Care center that treats illnesses and injuries requiring immediate care, but not serious enough to require an Emergency department visit.
- It is important to note that returning home from a visit with durable medical equipment, such as crutches, may result in an additional copayment.

| Virtual Visits | In-Network | Out-of-Network |
|---|---|---|
| **Virtual Visit (Designated Provider)** | $0 copayment / visit | Not Applicable |

**Notes:**

- Refer to the MyBind mobile app for additional coverage information.
- Please see the Behavioral Health and Office Visit sections for additional information on Telehealth Visits with your Provider.
- Virtual visits for Covered Health Services that include the diagnosis and treatment of low-acuity medical and mental health conditions for Participants, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care Specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).
- Benefits are available only when services are delivered through a designated virtual network Provider.
- Please note that not all medical conditions can be treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which in-person Physician contact is needed.
- No virtual visit coverage for out-of-network Providers.
- Services for email, standard telephone calls, or Telehealth visits that occur within medical facilities (CMS-defined originating facilities) are provided under the Office Visit and Diagnostic Visit Benefits section.
- Please visit the MyBind mobile app or MyBind.com website or call Bind Help to locate a designated virtual network Provider.

## Clinical Trials

Clinical trials are research studies designed to find ways to improve health care or to improve prevention, diagnosis, or treatment of health problems. The purpose of many clinical trials is to find out whether a medicine or treatment is safe and effective for treating a certain condition or disease. Clinical trials compare the effectiveness of medicines or treatments against standard, accepted treatment, or against a placebo if there is no standard treatment.

Participants in clinical trials are typically randomized to different treatment arms and based on that randomization may receive either the study intervention or the control intervention.

Services provided in a clinical trial typically include the interventions being evaluated (study agent and control agent) and other clinical services required to evaluate the effectiveness and safety of the interventions being compared.

In compliance with federal law, your Benefits cover routine health care costs for qualifying individuals participating in an approved clinical trial. For more information call Bind Help at the number on your member ID card.

Clinical Trial services may require Prior Authorization and Medical Necessity review.

## Coverage with Evidence Development

Bind implements written "Coverage with Evidence Development" ("CED") medical policies in order to accelerate the discovery and adoption of health care services that generate better clinical outcomes at lower cost. CED medical policies provide coverage for promising new technologies that have not yet been established as effective according to generally accepted professional medical standards, but:

1. Are not eligible to be covered under the clinical trials policy.
2. Would otherwise be considered Medically Necessary.
3. Are safe.
4. Show substantial potential to improve health outcomes and reduce waste and inefficiency in the health care system.
5. Are being evaluated in a high-quality research or clinical study.
6. Can be operationally administered by Bind.
7. Do not substantially increase health care costs.
8. Meet all of the requirements defined by the Bind clinical rationale policy and procedures.

Services covered by a CED policy are covered according to the Bind Plan benefit design. This will require Prior Authorization and Medical Necessity review.

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## 5.2 Prescription Drugs

See Section 13, Attachment I – Outpatient Prescription Drugs

## 5.3 Conditional Coverages

Once enrolled in the Bind Plan, any Participant is eligible to elect and activate conditional coverages. Conditional coverages include select, planned tests, treatments, or therapies that often have varying Provider and location options. Service(s) must be provided within the time frame shown in the conditional coverage period column below. Conditional coverage services must be Medically Necessary.

Conditional coverage is effective three business days after it is elected, and all services related to the conditional coverage must be complete within 120 days of its Effective Date. If you need any of these tests, treatments or therapies because it directly relates to an Emergency, trauma event, or cancer-related treatment (i.e., post-diagnosis) including surgery, you do not need to elect and activate conditional coverage as these situations are already covered by your Bind Plan. More information can be found on the MyBind mobile app or MyBind.com website or by contacting Bind Help.

The conditional coverage copayments listed below are maximum copayments. You may be eligible for reduced copayments if you use in-network Providers that Bind has designated as preferred, high-value Providers. Bind determines which in-network Providers are preferred, high-value Providers by considering, for example, their rates of effectiveness, low risk of complications, and the total cost charged by the Provider.

Some conditional coverages may be covered under the Bind Plan, without requiring you to elect and activate the conditional coverage, if you or your dependent meet certain age requirements. Please call Bind Help for additional information.

To elect a conditional coverage into your benefit package you **must** take the following steps to activate the coverage – at least three business days in advance of receiving the conditional coverage test, treatment, or therapy unless you expressly and permanently opt-out of the three-business-day waiting period for that specific elected and activated conditional coverage – in order to have coverage for the test, treatment, or therapy:

(1) Choose the conditional coverage test, treatment, or therapy.

(2) Choose the Provider and location for the test, treatment, or therapy.

(3) Attest to the Adverse Health Factor.

(4) Review the total cost of the test, treatment, or therapy.

(5) Click “Activate Coverage” to complete the activation process. *

**If the Participant electing and activating conditional coverage is a dependent, the subscriber must complete a sixth step and finally approve the conditional coverage election to fully complete the*

*activation process. The waiting period starts after the subscriber approves the conditional coverage election.*

You can elect and activate coverage yourself on the MyBind mobile app or MyBind.com website or call Bind Help for assistance. If you do not elect and activate the conditional coverage you need so it is effective in advance of you receiving the test, treatment, or therapy, you will not have coverage under the Bind Plan for the test, treatment, or therapy.

Unless you expressly and permanently chose to opt-out of the three-business-day waiting period for that specific elected and activated conditional coverage, you may cancel the conditional coverage within the three-business-day waiting period on the MyBind mobile app or MyBind.com website or call Bind Help for assistance. Once the conditional coverage is properly activated and effective, it cannot be cancelled for the duration of the coverage period.

| Conditional Coverages | In-Network Max Copayment | Out-of-Network Max Copayment | Coverage Period |
|---|---|---|---|
| **Ankle and Foot Bone Fusion** | $2,000 | $2,400 | 120 days |
| **Ankle Arthroscopy and Ligament Repair** | $2,000 | $2,400 | 120 days |
| **Ankle Replacement and Revision** | $2,000 | $2,400 | 120 days |
| **Back Surgery, Cervical Spine Disc Decompression** | $2,000 | $2,400 | 120 days |
| **Back Surgery, Cervical Spine Fusion** | $2,000 | $2,400 | 120 days |
| **Back Surgery, Lumbar Spine Disc Decompression** | $2,000 | $2,400 | 120 days |
| **Back Surgery, Lumbar Spine Fusion** | $2,000 | $2,400 | 120 days |
| **Breast Reduction Surgery*** | $2,000 | $2,400 | 120 days |
| **Bunionectomy and Hammertoe Surgery** | $1,600 | $1,900 | 120 days |
| **Cardiac Ablation** | $2,000 | $2,400 | 120 days |
| **Carotid Endarterectomy and Stents** | $2,000 | $2,400 | 120 days |
| **Carpal Tunnel Surgery** | $1,150 | $1,400 | 120 days |
| **Cataract Surgery** | $1,000 | $1,100 | 120 days |
| **Coronary Artery Bypass Graft Surgery** | $2,000 | $2,400 | 120 days |
| **Coronary Catheterization and Percutaneous Coronary Intervention** | $2,000 | $2,400 | 120 days |
| **Ear Tubes** | $1,100 | $1,300 | 120 days |
| **Elbow Arthroscopy and Tenotomy** | $1,350 | $1,600 | 120 days |
| **Elbow Replacement and Revision** | $2,000 | $2,400 | 120 days |
| **Fibroid Removal (Myomectomy)** | $2,000 | $2,400 | 120 days |
| **Gallbladder Removal Surgery (Cholecystectomy)** | $1,800 | $2,150 | 120 days |
| **Ganglion Cyst Surgery** | $1,150 | $1,400 | 120 days |
| **Hernia Repair** | $1,750 | $2,100 | 120 days |
| **Hip Arthroscopy and Repair** | $2,000 | $2,400 | 120 days |
| **Hip Replacement and Revision** | $2,000 | $2,400 | 120 days |
| **Hysterectomy*** | $2,000 | $2,400 | 120 days |

| Conditional Coverages | In-Network Max Copayment | Out-of-Network Max Copayment | Coverage Period |
|---|---|---|---|
| **Hysteroscopy and Endometrial Ablation** | $1,350 | $1,600 | 120 days |
| **Kidney Stone Ablation and Removal (Lithotripsy)** | $1,600 | $1,900 | 120 days |
| **Knee Arthroscopy and Repair** | $1,650 | $2,000 | 120 days |
| **Knee Replacement and Revision** | $2,000 | $2,400 | 120 days |
| **Morton's Neuroma Surgery** | $1,300 | $1,550 | 120 days |
| **Pacemakers and Defibrillators** | $2,000 | $2,400 | 120 days |
| **Plantar Fasciitis Surgery** | $1,350 | $1,600 | 120 days |
| **Prostate Removal Surgery** | $1,650 | $2,000 | 120 days |
| **Reflux and Hiatal Hernia Surgery** | $2,000 | $2,400 | 120 days |
| **Shoulder Arthroscopy and Repair** | $2,000 | $2,400 | 120 days |
| **Shoulder Replacement and Revision** | $2,000 | $2,400 | 120 days |
| **Sinus and Nasal Septum Surgery** | $1,800 | $2,150 | 120 days |
| **Sling Surgery for Female Urinary Incontinence** | $2,000 | $2,400 | 120 days |
| **Spinal Cord Stimulators** | $1,050 | $1,200 | 120 days |
| **Tonsillectomy and Adenoidectomy** | $1,250 | $1,500 | 120 days |
| **Upper GI Endoscopy** | $1,000 | $1,150 | 120 days |
| **Valve Replacement** | $2,000 | $2,400 | 120 days |
| **Wrist and Hand Joint Replacement** | $1,600 | $1,900 | 120 days |
| **Wrist Arthroscopy and Repair** | $1,450 | $1,750 | 120 days |

*Hysterectomy procedure and Breast reduction surgery for the treatment of Gender Dysphoria are covered under the Bind Plan and require Prior Authorization.

Conditional coverage provides coverage on the same date of the surgery or during the same hospital admission for the following associated Covered Health Services:

- Anesthesia
- Facility charges
- Labs
- Medications administered by a Provider
- Pathology
- Provider services
- Radiology
- Supplies

## Exclusions to Conditional Coverages

- For conditional coverages performed in a clinic or outpatient facility: Covered Health Services provided prior to and after the date of the test, treatment, or procedure even if such services

are directly related to the same or similar conditional coverage body part are not included in the conditional coverage copayment. Coverage may already be available for such services under the Bind Plan.

- For conditional coverages performed in an inpatient facility: Covered Health Services provided prior to an admission and after a discharge from an inpatient facility even if such services are directly related to the same or similar conditional coverage body part are not included in the conditional coverage copayment. Coverage may already be available for such services under the Bind Plan.
- Health care services that are not Medically Necessary.
- Items listed in Section 6 (What Is Not Covered).

## 5.4 Prior Authorization and Pre-Admission Notification

Select services require Prior Authorization or Pre-Admission Notification. Prior Authorization is required by service type, regardless of whether the service is rendered by in-network or out-of-network Providers.

In-network Providers are responsible for obtaining Prior Authorization for select Covered Health Services and are responsible for Pre-Admission Notification for planned inpatient admissions and post-admission notification at least 24 hours of admission of Emergency inpatient admissions. Prior Authorization is not required for conditional coverages; however, if the procedure is being performed in an inpatient setting, the Provider is responsible for Pre-Admission Notification at least 24 hours prior to admission. Inpatient stays will be reviewed for Medical Necessity, length of stay, and level of care. All acute inpatient rehabilitation (AIR) admissions, long-term acute care (LTAC) admissions, and Skilled Nursing Facility (SNF) admissions are subject to Medical Necessity review pre-admission. If you have questions about Prior Authorization or Pre-Admission Notification, please contact Bind Help.

If you are using an out-of-network Provider, you are responsible for ensuring that any necessary Prior Authorizations and Pre-Admission Notifications have been obtained or the services may not be covered by the Bind Plan. Contact Bind Help prior to obtaining services to determine whether Prior Authorization is required or ask your Provider to contact the pre-certification number on your member ID card.

If your Prior Authorization or Pre-Admission Notification is denied, you will receive an explanation of why it was denied and how you can appeal (including how to request expedited review). This information can also be found in Section 8 (What Do I Do If My Claim Is Denied).

The Prior Authorization list is subject to change without notice. The most current information can be obtained by having your Provider contact the pre-certification number on your member ID card or call Bind Help.

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Prior Authorization may be required for certain services/procedures. The list below is not all inclusive and can change from time to time, so it is important your Provider check with the Plan to verify if a Prior Authorization is required prior to services being rendered.

- Acute care hospitalizations (planned)
- Acute inpatient rehabilitation
- Applied behavioral analysis
- Non-Emergency air transportation
- Bone growth stimulators
- BRCA testing
- Select cardiovascular procedures
- Select chemotherapy
- Clinical trials
- Cochlear implant surgery
- Coverage with Evidence Development
- Potentially Cosmetic and Reconstructive surgery
- Select durable medical equipment, orthotics, and prosthetics
- Gender reassignment surgery
- Select genetic and molecular tests
- Select injectable medications
- Intensity-modulated radiation therapy
- Long-term acute care
- MR-guided focused ultrasound
- Organ transplants
- Orthognathic surgery
- Partial hospitalization
- Proton beam therapy
- Residential treatment facilities
- Skilled Nursing Facilities
- Sleep apnea procedures
- Sleep studies
- Select spinal surgeries
- Vein procedures
- Ventricular assist devices

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## 5.5 Clinical Programs

### Bind Care Management

Bind Care Management offers support to help you use your Benefits, improve your health, and achieve an optimal quality of life.

Our care managers act as an advocate for you and your family by:

- Assisting you in making important health care decisions.
- Coordinating your care with your health care Providers.
- Helping you develop self-management skills.
- Identifying available treatment options.
- Offering personalized coaching to help you live better with an illness or recover from an acute condition.
- Researching resources, such as Care Model Innovations (see below), support groups, and financial assistance.

Although your care manager will be your primary program contact, you and your Physician will always make the decisions about your treatment. By working closely with your Physician and using the resources available in your community, this program can help you through a difficult time.

It is your choice to participate in Bind Care Management. There are no extra charges for these services, and you can end your participation at any time, for any reason. Participation in this program will not affect your Benefits. Contact Bind Help if you think you can use this support.

### Transplant Resource Services

For a solid organ and blood/marrow transplant to be a Covered Health Service, you must be enrolled in Transplant Resource Services and use a facility designated as a Transplant Center of Excellence. Most transplants are expensive and complicated. At Bind, we ensure you are going to a reputable facility that has expertise in the specific type of transplant you need. Contact Bind Help at the number on your member ID card for more information on Transplant Resource Services and access to Transplant Center of Excellence Providers.

Once you are enrolled in Transplant Resource Services, a dedicated nurse case manager who specializes in transplant cases will provide assistance in:

- Selecting the transplant facility.
- Scheduling your evaluation at the transplant facility.
- Following up with you routinely while you are on the transplant list.
- Discharge planning, post-transplant support, and ongoing help with your care needs.

Organs included in the program are heart, heart/lung, lung, kidney, kidney/pancreas, pancreas, liver, liver/intestine, intestine, and bone marrow (blood forming stem cell transplants). While corneal

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transplant is a solid tissue transplant, it is not considered part of the Transplant Centers of Excellence program.

## Bind Care Model Innovations

A Care Model Innovation (CMI) program is a Provider contracted with Bind to provide health-related services that prevent, treat, or reverse one or more chronic diseases or conditions. CMI services may include education, decision-support, coaching, nutritional support, caregiver support, meditation, therapeutic movement, and other therapeutic or diagnostic services that would not otherwise be considered Medically Necessary, or would be excluded Benefits, if provided outside of a Bind CMI program.

Bind may offer additional or varying CMI programs throughout the year. To find out additional information, visit the MyBind mobile app or MyBind.com website or call Bind Help.

### Maternity Support Program

Bind offers a maternity support program with round-the-clock access to maternity nurses, lactation consultants, and early childhood experts. To find out additional information, visit the MyBind mobile app or MyBind.com website or call Bind Help, or go to www.pacify.com/bind.

## Other Condition-Focused Programs Made Available by UHG Inc

### NurseLine℠ – See Attachment II

NurseLine℠ is a telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information to help you make more informed health care decisions.

### Real Appeal Weight Loss Program– See Attachment III

Real Appeal is an online weight management program free to Participants and their spouses/domestic partners enrolled in the Bind Plan. The program uses a tailored approach, including group and individual counseling sessions, to help people lose weight and build positive, sustainable lifestyle changes.

### UnitedHealthcare Hearing – See Attachment IV

UnitedHealthcare Hearing helps make hearing health care more accessible and affordable by offering innovative hearing solutions that deliver choice, convenience, and value to you and your families.

### Level2 -See Attachment V

Level2™ is a program offering personalized and data-driven care for individuals, enrolled in the Bind Plan, with Type 2 diabetes. Through an individualized approach, guided by wearable technologies and personal coaching, Level2 focuses on the reduction of A1C, increasing time in range of blood glucose levels, and the possibility of Type 2 diabetes remission.

**Medical Weight Loss -Attachment VI**

Medical Weight Loss focuses on understanding the underlying conditions, medications and lifestyle behaviors that may affect weight loss efforts and offers a comprehensive evidence-based treatment plan to meet your unique needs.

**Rewards for Health -Attachment VII**

Rewards for Health offers comprehensive, personalized health recommendations based on data from your health survey, biometrics and other health information. Your recommended actions will expand over time as Rewards for Health receives additional data. You'll receive more rewards for actions that are proven to have better outcomes for your health. Participation in Rewards for Health is voluntary. However, to earn rewards, you will have to participate in the program activities.

## 5.6 Transition of Care and Continuity of Care

If you are new to the Bind Plan and are actively receiving treatment from a Provider who is not in our network, you may be eligible to receive Transition of Care Benefits. Transition of Care Benefits allow you the option to request coverage from your current out-of-network Provider at in-network copayments for a limited time due to a qualifying medical condition until the safe transfer to an in-network Provider can be arranged.

If you are currently covered by the Bind Plan and your health care Provider leaves the network, you can apply for Continuity of Care. If you are approved, Continuity of Care Benefits will allow you the option to request extended care from your out-of-network Provider while paying in-network copayments until a safe transition can be made to an in-network Provider.

The following criteria must be met for your Transition of Care or Continuity of Care application to be considered:

- **Transition of Care**: You are **newly** eligible for the Bind Plan and currently receiving care for a Covered Health Service by an in-network Provider and your Provider is no longer in-network under the Bind Plan.
- **Continuity of Care**: You are **currently** enrolled in the Bind Plan and actively receiving care for a Covered Health Services by an in-network Provider, who subsequently leaves the network and becomes an out-of-network Provider.

**In addition, you must have at least one of the following:**

- **Inpatient and Residential Care:** If you are actively receiving inpatient or residential care at a Provider that was in-network and becomes out-of-network, you may qualify for Transition of Care or Continuity of Care Benefits to cover the duration of the inpatient or residential care stay.
- **Scheduled Surgery/Procedure:** If you have a scheduled procedure with an in-network Provider who becomes out-of-network, you may quality for Transition of Care or Continuity of

Care Benefits if the procedure is scheduled to take place within 120 days after the Participant's Effective Date or Provider termination date and is authorized for continued care by the Bind Plan.

- **Pregnancy:** If you are in your second trimester of pregnancy or are earlier in your pregnancy but considered high-risk and are receiving care from a Provider who was in-network and becomes out-of-network, you may quality for Transition of Care and Continuity of Care Benefits. If approved, these Benefits typically extend through two months after giving birth.
- **Serious Chronic Condition:** If you are actively being treated for a serious chronic medical condition which may persist or worsen if care is delayed and are receiving care from a Provider who was in-network and becomes out-of-network, you may quality for Transition of Care and Continuity of Care Benefits. If approved, these Benefits typically are covered for 120 days after the Participant's Effective Date or Provider termination date.
- **Terminal Illness:** If you have an incurable or irreversible condition that has a probability of causing death within one year or less and are receiving care from a Provider who was in-network and becomes out-of-network, you may qualify for Transition of Care and Continuity of Care Benefits. If approved, these Benefits typically are covered for 120 days after the Participant's Effective Date or Provider termination date.
- **Transplant:** If you are the recipient of an organ transplant and in need of ongoing care due to complications associated with the transplant and are receiving care from a Provider who was in-network and becomes out-of-network, you may qualify for Transition of Care and Continuity of Care Benefits. If approved, these Benefits typically are covered for 120 days after the Participant's Effective Date or Provider termination date.

To request an application for Transition of Care (new Participants) or Continuity of Care (existing Participants), call Bind Help at the number on your Bind member ID card. The application must be completed and returned within 30 days of the Effective Date of coverage for new Participants or within 30 days of the Provider leaving the network for existing Participants. After receiving your request, Bind will review and evaluate the information provided and send you a letter to let you know if your request was approved or denied. A denial will include information about how to appeal the determination.

# 6. What Is Not Covered

The Bind Plan does not provide Benefits for the following services, treatments, or supplies even if they are recommended or prescribed by a Provider or are the only available treatment for your condition, unless specifically described or listed in Section 5.1 (Covered Health Services).

## Alternative Treatments

1. Aromatherapy.
2. Art therapy, dance therapy, horseback therapy, music therapy, and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health.
3. Health care services ordered or rendered by Providers or para-professionals unlicensed by the appropriate regulatory agency.
4. Holistic medicine and services, including dietary supplements.
5. Homeopathic or naturopathic medicine, including dietary supplements.
6. Hypnotism.
7. Massage therapy that is not physical therapy or prescribed by a licensed Provider as a component of a multi-modality rehabilitation treatment plan.
8. Rolfing.
9. Vocational therapy.

## Behavioral Health: Mental Health/Substance Use Disorder

10. Educational/behavioral services that are focused primarily on building skills and capabilities in communication, social interaction, and learning.
11. Inpatient or intermediate or outpatient care services that were not pre-authorized.
12. Investigational therapies for treatment of autism.
13. Non-medical 24-hour withdrawal management which is an organized residential service, including those defined in the *American Society of Addiction Medicine (ASAM)* criteria 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.
14. 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 Mental Disorders by the American Psychiatric Association*.
15. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, kleptomania, gambling disorder, paraphilic disorder, and pyromania.

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16. 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 Mental Disorders by the American Psychiatric Association*.
17. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association*.
18. Transitional living services.
19. 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.
20. Unproven intensive behavioral therapy treatment programs for the treatment of Autism Spectrum Disorders, including Intense Early Intervention Using Behavioral Therapy (IEIBT) and Lovaas.
21. Vagus nerve stimulator treatment for the treatment of depression and quantitative electroencephalogram treatment of behavioral health conditions.
22. Wilderness therapy, nature camps, and similar arrangements.

## Conditional coverages

23. Health care services listed as a conditional coverage in Section 5.3 (Conditional Coverages), are not covered by the Bind Plan unless you elect and activate the coverage or except for Emergency, trauma, or cancer-related treatments (i.e., post-diagnosis).

## Dental

24. Dental braces (orthodontics).
25. Dental care (which includes dental X-rays, supplies, and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to dental care required for the direct treatment of a medical condition.
26. Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental tooth decay or cavities resulting from dry mouth after radiation treatment or as a result of medication.
27. Dental implants, bone grafts, and other implant-related procedures.
28. Endodontics, periodontal surgery, and restorative treatments are excluded.
29. Preventive care, diagnosis, and treatment of or related to the teeth, jawbones, or gums.
30. Removal of impacted teeth, including but not limited to wisdom teeth.
31. Treatment of congenitally missing, malpositioned or supernumerary (extra) teeth, even if part of a congenital anomaly.

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## Devices, Appliances, Supplies and Prosthetics

32. Communication aids or devices; equipment to create, replace, or augment communication abilities, including but not limited to communication board or computer or electronic-assisted communication, speech processors, and receivers.
33. Cranial banding except when Medically Necessary for the treatment of plagiocephaly (head asymmetry) and craniosynostosis (abnormal head shape).
34. Devices and computers to assist in communication and speech.
35. Devices used specifically as safety items or to affect performance in sports-related activities.
36. Disposable supplies for home use such as, but not limited to Ace-type bandages, antiseptics, bandages, diapers, dressings, incontinence supplies, gauze, and tape.
37. Home testing devices and monitoring equipment except as specifically provided in the Durable Medical Equipment Benefits.
38. Household equipment, household fixtures, and modifications to the structure of the home, escalators or elevators, hot tubs and saunas, ramps, swimming pools, whirlpools, wiring, plumbing, or charges for installation of equipment, exercise cycles, air purifiers, central or unit air conditioners, hypo-allergenic pillows, mattresses, water purifiers, or waterbeds.
39. Oral appliances for snoring.
40. Orthotic appliances and devices that straighten or re-shape a body part. Examples of excluded orthotic appliances and devices include but are not limited to some types of braces, and arch supports, and include orthotic braces available over-the-counter.
41. Over-the-counter medical equipment or supplies such as saturation monitors, prophylactic knee braces, and bath chairs that can be purchased without a prescription even if a prescription has been ordered.
42. Repairs to prosthetic devices due to misuse, malicious damage, or gross neglect.
43. Replacement of prosthetic devices due to misuse, malicious damage, or gross neglect or to replace lost or stolen items.
44. Shoes. This exclusion does not apply to therapeutic, custom-molded shoes when prescribed by a Physician.
45. Shoe orthotics. This exclusion does not apply to therapeutic shoe orthotics when prescribed by a Physician.
46. Supplies, equipment, and similar incidentals for personal comfort. Examples include air conditioners, air purifiers, exercise equipment, humidifiers, Jacuzzis, recliners, saunas, and vehicle modifications such as van lifts.
47. Vehicle/car or van modifications including, but not limited to, car carriers, handbrakes, and hydraulic lifts.

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## Drugs

48. A Prescription Drug Product that contains marijuana, including medical marijuana.
49. Certain Prescription Drug Products that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. The Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
50. Charges for giving injections that can be self-administered.
51. Diagnostic kits and products, except as covered under Section 13 (Attachment I - Outpatient Prescription Drugs). Examples include barium, drug assay test kits, DNA collection kits, and urine collection kits.
52. Drugs dispensed by a Physician or Physician's office for outpatient use.
53. Growth hormone therapy, except when approved and provided as a Prescription Drug benefit, for a documented growth hormone deficiency, Turner's Syndrome, growth delay due to a cranial radiation or chronic renal disease, Gender Dysphoria, or autoimmune deficiency.
54. Investigational or non-FDA-approved drugs.
55. Non-prescription supplies.
56. Over-the-counter drugs, except as specified in Section 13 (Attachment I – Outpatient Prescription Drugs).
57. Prescription Drug Products when prescribed to treat infertility.
58. Publicly available software applications that may be available with or without a Prescription Order or Refill.
59. Selected drugs or classes of drugs which have shown no benefit regarding efficacy, safety, or side effects.
60. Unit dose packaging or repackagers of Prescription Drug Products.
61. Vitamin or dietary supplements, except as specified in Section 13 (Attachment I – Outpatient Prescription Drugs).

## Experimental or Investigational or Unproven Services

62. Biofeedback that is Experimental or Investigational or Unproven.
63. Intracellular micronutrient testing.
64. Services that are considered Experimental or Investigational as determined by Bind are excluded. The fact that an Experimental or Investigational treatment, device, or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational in the treatment of that particular condition. To find out additional information, call Bind Help.

## Foot Care

65. Hygienic and preventive maintenance foot care.
66. Routine foot care (except for standard diabetic foot care). Examples include the cutting or removal of corns and calluses.

## Gender Dysphoria

67. Cosmetic procedures related to a diagnosis of Gender Dysphoria including:
    a) Abdominoplasty.
    b) Blepharoplasty.
    c) Body contouring, such as lipoplasty or liposuction.
    d) Breast augmentation, implants, and reconstruction.
    e) Brow lift, face lift, forehead lift, or neck tightening.
    f) Calf implants.
    g) Cheek, chin, and nose implants.
    h) Chondrolaryngoplasty; thyroid cartilage reduction, reduction of thyroid, trachea shave (removal or reduction of the Adam's apple).
    i) Facial bone remodeling for facial feminizations.
    j) Hair removal and transplantation.
    k) Head width reduction.
    l) Injection of fillers or neurotoxins.
    m) Lip reduction and augmentation.
    n) Liposuction.
    o) Mastopexy.
    p) Pectoral implants for chest masculinization.
    q) Rhinoplasty
    r) Skin resurfacing.
    s) Voice lessons and voice therapy.
    t) Voice modification surgery.

## Nutrition

68. Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU).
69. Nutritional or Cosmetic therapy using high-dose or mega quantities of vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high-protein foods and low-carbohydrate foods).

## Physical Appearance

70. Breast reduction surgery that is determined to be a Cosmetic procedure except as required by the Women's Health and Cancer Rights Act of 1998.
71. Cosmetic Procedures and items that change or improve physical appearance without significantly improving physiological function, such as:
    a) Hair removal or replacement by any means.
    b) Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
    c) Pharmacological regimens, nutritional procedures, or treatments.
    d) Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery, and other such skin abrasion procedures).
    e) Skin abrasion procedures performed as a treatment for acne.
    f) Treatments for hair loss.
    g) Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
    h) Treatment for spider veins of the lower extremities when it is considered Cosmetic.
    i) Varicose vein treatment of the lower extremities when it is considered Cosmetic.
72. Excision or removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
73. Physical conditioning programs such as athletic training, bodybuilding, diversion or general motivation, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation.
74. Reconstructive surgery where there is another more appropriate covered surgical procedure or when the proposed Reconstructive surgery offers minimal improvement in your appearance. This exclusion shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.
75. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic procedure.
76. Treatment of benign gynecomastia (abnormal breast enlargement in males).
77. Weight loss programs, whether or not they are under medical supervision or for medical reasons, even if for morbid obesity. Certain medical weight loss programs are provided under the Medical Weight Loss program. See Attachment VI for more information.
78. Wigs (scalp/cranial hair prostheses) except for Participants with scalp/head wound, burns, injuries, alopecia areata, and cancer who are undergoing chemotherapy or radiation therapy.

## Procedures and Treatments

79. Bariatric surgery.

80. Chelation therapy, except to treat heavy metal toxicity and overload conditions.
81. Elective abortion, except in situations where the life of the covered Participant (mother) would be endangered if the fetus is carried to full term.
82. Helicobacter pylori (H. pylori) serologic testing.
83. Home births.
84. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
85. Outpatient cognitive rehabilitation therapy except as Medically Necessary following traumatic brain Injury or cerebral vascular accident.
86. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
87. Rehabilitation services/chiropractic care, spinal treatment, and manipulative treatment to improve general physical condition and not therapeutic in nature that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term, or maintenance/preventive treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.
88. Rehabilitation services for speech therapy, except as required for treatment of a speech impediment or speech dysfunction that results from injury, stroke, cancer, or congenital anomaly.
89. Speech therapy to treat stuttering, stammering, or other articulation.
90. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care Providers specializing in smoking cessation and may include a psychologist, social worker, or other licensed or certified professional. The programs usually include behavior modification techniques, intensive psychological support, and medications to control cravings.

## Providers

91. Services ordered or delivered by a Christian Science practitioner.
92. Services performed by a Provider who is a family member by birth or marriage, including your spouse, domestic partner, brother, sister, parent, or child. This includes any service the Provider may perform on himself or herself.
93. Services performed by a Provider with your same legal residence.
94. Services performed by an unlicensed Provider or a Provider who is operating outside of the scope of his/her license.
95. Services, supplies, and treatment for which the Provider bills the Plan separately, when charges would normally be included in the charge for a completed Covered Health Service.

## Reproduction

96. Services related to the treatment of infertility, including:
    a) All charges associated with a gestational carrier program for the person acting as the carrier, including but not limited to, fees for laboratory tests.
    b) All costs associated with surrogate parenting including, but not limited to, donor oocytes (eggs), donor sperm and host uterus.
    a) Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes.
    b) Assisted Reproductive Technologies (ART), including but not limited to, gamete intrafallopian transfer (GIFT), intrauterine insemination (IUI), in-vitro fertilization (IVF), pronuclear stage tubal transfer (PROST), tubal embryo transfer (TET), and zygote intrafallopian transfer (ZIFT).
    c) Cloning.
    d) Cryopreservation and storage.
    e) Donor ovum or oocytes (eggs), embryos, and semen and related costs, including collection, preparation, and storage of.
    f) Donor services and non-medical costs of oocyte or sperm donation (e.g., donor agency fees).
    g) Embryo or oocyte accumulation, defined as a fresh oocyte (egg) retrieval prior to the depletion of previously banked frozen embryos or oocytes (eggs).
    h) Ovulation predictor kits.
    i) Reversal of voluntary sterilization.

## Services Provided Under Another Plan

97. Services for which coverage is available:
    a) For treatment of military service-related disabilities when you are legally entitled to other coverage and facilities are reasonably available to you.
    b) Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
    c) Under another medical plan, except for Eligible Expenses payable as described in this SPD.
    d) Under Workers' Compensation or similar legislation if you could elect it or could have it elected for you.
    e) While on active military duty.

## Transplants

98. Health services for transplants involving permanent mechanical or animal organs.

99. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's medical coverage.)

## Travel

100. Health services provided in a foreign country, unless determined to be an Emergency.
101. Travel or transportation expenses, even if ordered by a Physician, except as identified under ambulance and transplant in Section 5.1(Covered Health Services).

## Types of Care

102. Custodial Care.
103. Domiciliary Care.
104. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
105. Private Duty Nursing.
106. Respite care, except as defined under Hospice Care in Section 5.1 (Covered Health Services).
107. Rest cures.
108. Services of personal care attendants.
109. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

## Vision, Hearing and Voice

110. Eye exercise or vision therapy.
111. Implantable lenses used only to correct a refractive error, such as radial keratotomy or related procedure, and artificial retinal devices or retinal implants.
112. Refractive surgery (e.g., Lasik) for ophthalmic conditions that are correctable by contact lenses or glasses.
113. Comprehensive vision exams, routine vision exams (including refractions), eyeglasses, contact lenses and any fittings associated with them, except as identified in Section 5.1 (Covered Health Services).
114. Surgery and other related treatment that is intended to correct farsightedness, nearsightedness, presbyopia, and astigmatism, including but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.
115. Hearing aids not purchased through UnitedHealthcare Hearing.
116. Hearing aid batteries* and supplies (e.g., sound tubes, ear tips, sound receivers, etc.). *Unless provided through Advanced technology level or Premium technology level through UnitedHealthcare Hearing.

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117. Purchase cost and associated fitting and testing charges for Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices.
118. Any type of communicator, electronic voice producing machine, voice enhancement, voice prosthesis, or any other language assistive devices.

## All Other Exclusions

119. Autopsies and other coroner services and transportation services for a corpse.
120. Charges for:
    a) Completion of Claim forms.
    b) Missed appointments.
    c) Record processing.
    d) Room or facility reservations.
121. Charges prohibited by federal anti-kickback or self-referral statutes.
122. Direct-to-consumer retail genetic tests.
123. Expenses for health services and supplies:
    a) For which the Participant has no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Bind Plan.
    b) For illness or injury occurring during illegal acts.
    c) That are received after the date the Participants coverage ends, including health services for medical conditions which began before the date the Participants coverage ends.
    d) That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Participants who are civilians injured or otherwise affected by war, any act of war, or terrorism in a non-war zone.
    e) That exceed Eligible Expenses or any specified limitation in this SPD.
124. Foreign language and sign language services.
125. Health care services that Bind determines are not Medically Necessary.
126. Long-term (more than 30 days) storage of blood, umbilical cord, or other material (e.g., cryopreservation of tissue, blood, and blood products).
127. Medical and surgical treatment of excessive sweating (hyperhidrosis).
128. Over-the-counter self-administered home diagnostic tests (except direct-to-consumer/home-based tests), including but not limited to HIV, ovulation, and pregnancy tests.
129. Personal comfort items or services such as television, telephone, barber or beauty services, guest services and similar incidental services and supplies.
130. Physical, psychiatric, or psychological exams, testing, and all forms of vaccinations and immunizations or treatments when:

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a) Conducted for purposes of medical research.
b) Related to judicial or administrative proceedings or orders, unless determined to be Medically Necessary.
c) Required solely for purposes of adoption, career or employment, education, insurance, marriage, sports or camp, travel, or as a result of incarceration.
d) Required to obtain or maintain a license of any type.

131. Health care services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services that would otherwise be determined to be a Covered Health Service if the service treats complications that arise from the non-Covered Health Service. For the purpose of this exclusion a “complication” is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition.

# 7. Medical Claims Procedures

When you receive in-network services, the Provider will generally collect your copayment from you at the time of your treatment and send a medical Claim to the Bind Plan for payment. Sometimes out-of-network Providers will do the same. Other times, out-of-network Providers may bill you for the total cost of your treatment, and you will need to submit the medical Claim to the Bind Plan to be reviewed for Benefits. Whether you pay out-of-pocket, or your Provider bills the Bind Plan directly, you are still entitled to the same Benefits.

If you receive a bill from your Provider (whether in-network or out-of-network) for the Bind Plan's portion of the costs, or you pay for your medical care out-of-pocket and need to be reimbursed, you must submit a medical Claim to the Bind Plan. This section summarizes the procedures you must follow to submit a medical Claim for payment, and the procedures the Bind Plan will use to determine whether and how much to pay for that medical Claim.

If you would like more details about medical Claims procedures and your rights and responsibilities, contact Bind Help.

## Regular Post-Service Medical Claims

Post-service medical Claims are non-urgent medical Claims processed after you have received treatment. Pre-Service and Urgent Care Request for Benefits are described in Section 8 (What Do I Do If My Claim Is Denied). Generally, you do not need to file a medical Claim for services from in-network Providers; the Provider will handle the filing of the medical Claim. For out-of-network Providers that do not file medical Claims or if you receive Emergency care outside the United States and are seeking reimbursement from the Bind Plan, you can submit a medical Claim using this procedure.

You can submit a post-service medical Claim by mail to the address on your member ID card. You will need to provide several pieces of information for Bind to be able to process your medical Claim and determine the appropriate Bind Plan Benefits:

- The name and birthdate of the Participant who received the care.
- The Participant ID listed on the Bind member ID card.
- An itemized bill from your Provider, which should include:
  - The Provider's name, address, tax identification number, NPI number, and license number (if available).
  - The date(s) the Participant received care.
  - The diagnosis and procedure codes for each service provided.
  - The charges for each service provided.
- Information about any other health coverage the Participant has.
- Proof of payment may be requested to substantiate your medical Claim but is not required upon initial submission to Bind.

## Regular Post-Service Pharmacy Claims

See Section 13, Attachment I – Outpatient Prescription Drugs

Claims for pharmacy Benefits and appeals will be reviewed by OptumRx.

## Other General Medical Claims Procedures

Your medical Claim must be submitted within one year from the date you received the health care services. If you are not capable of submitting a medical Claim within one year, you must submit the medical Claim as soon as reasonably possible. If your medical Claim relates to an inpatient stay, the date you were discharged counts as the date you received the health care service for medical Claims purposes.

You will receive a decision within 30 days of submitting your medical Claim. If we need more information on a medical Claim, we will reach out to you to request that additional information, but we will still make a decision on your medical Claim within 30 days. If you submit the requested additional information after a decision has been made, we may adjust our decision and reprocess your medical Claim accordingly.

Claims for medical (non-pharmacy) Benefits will be reviewed by Bind. If more time is needed to decide your medical Claim, we may request a one-time extension of not more than 15 days.

If a Claim for a welfare benefit is denied or ignored, in whole or in part, a Participant has a right to know why this was done, to obtain copies of documents (without charge) relating to the decision, and to appeal any denial, all within certain time schedules.

## Notice of Adverse Claim Determination

If your medical Claim is denied in whole or in part, you will receive a written notice of denial. A description of additional information needed to support your medical Claim and an explanation of why it is needed.

- Information about how to appeal your Claim and any time limits, should you want to pursue it further and your right to bring a civil action under ERISA if your appeal is denied.
- A statement about available external review processes, including information on how to initiate the review.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, either a copy of the document or a statement that such a document was relied on and that a copy will be provided (free of charge) upon request.
- Either an explanation of the scientific or clinical judgment for the decision (applying the Plan terms to your medical circumstances) or a statement that such an explanation was relied on and that a copy will be provided (free of charge) upon request, if the decision was based on a limit (for example, a decision that the proposed service is not Medically Necessary).

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- A description of the expedited review process in the case of a denial concerning a Claim involving urgent care. If we tell you about our decision orally within the timeframes required, we will follow up within three business days with a written or electronic notice.
- A statement about the availability of contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.
- A description of any voluntary processes the Plan offers.

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# 8. What Do I Do If My Claim Is Denied?

## If Your Medical Claim is Denied

If a medical Claim for Benefits is denied in part or in whole, you are encouraged to call Bind Help before requesting a formal appeal. If Bind Help cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

To submit an appeal of a medical Claim:

1. Contact Bind Help to request an Appeal Filing Form or refer to the Appeal Filing Form included with your Explanation of Benefits.
2. Complete the Appeal Filing Form.
3. Submit the completed Appeal Filing Form along with your denial notice and any supporting documentation to:

   Bind Benefits, Inc.
   Appeals Department
   PO Box 211758
   Eagan, MN 55121

## If Your Prescription Claim is Denied

If an excluded drug is prescribed for a specific medical condition, you have the right to appeal. To appeal for an additional clinical review, submit a letter to UnitedHealthcare Appeals from your Physician stating the medical condition that requires the non-covered drug and the length of projected use. The maximum time for which a letter can qualify for an appeal is 12 months. If your appeal is approved, you will be able to purchase your prescription at your local network pharmacy or by mail order by paying the applicable copayment.

To file a prescription drug appeal, mail the appeal to:

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

Also refer to Attachment I – Outpatient Prescription Drugs, for additional information.

## Review of a Medical Claim Appeal

Bind will conduct a full and fair review of your medical Claim appeal.

You can send us written comments, documents, records, and any other information you think will help us decide the appeal.

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 the Participant's claim for medical Benefits. "Relates to" means at least one of the following:

- That we used the information to make the Benefit determination.
- The information was submitted, used, or created while making the Benefit determination.
- The information shows that we made the Benefit determination based on your Plan documents and made the same decision for other Plan Participants in the same situation.
- The information is one of our policies or guidance.

When we review your appeal, we will take into account all comments, documents, records, and other information you give us, even if we did not have that information when we denied the medical Claim.

Bind adheres to the following review practices:

- The appeal will be reviewed by an appropriate individual(s) who did not make the initial Benefit determination and who does not report to the person who did make the initial Benefit determination.
- If your medical Claim involves medical judgment or whether the medical Claim is about investigational or Experimental services, the appeal will be reviewed by a health care professional with appropriate expertise who was not consulted during the initial Benefit determination process.
- Bind will review all medical Claims in accordance with the rules established by the U.S. Department of Labor and applicable state law.
- Our reviewers avoid conflicts of interest and act independently and impartially. We do not hire, pay, terminate, promote, make decisions, or incentivize medical Claims reviewers to make denials.

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

If you are not satisfied with the first-level appeal decision, you have the right to request a second-level appeal within 60 days of receipt of the first-level appeal determination.

Bind will review your appeal and will notify you of its decision within 30 days of receipt.

## Access to New or Additional Information

If you ask us, we will give you the identification of any medical expert who gave us an opinion – whether or not we used that opinion to decide your medical Claim. Any Participant will be automatically provided, free of charge, and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is required, with: (i) any new or additional evidence considered, relied upon, or generated by the Bind Plan in connection with the medical Claim; and (ii) a reasonable opportunity for any Participant to respond to such new evidence or rationale.

## Pre-Service and Urgent Care Request for Medical Benefits

A pre-service request for medical Benefits is a type of Benefit request that requires Prior Authorization but is not urgent. An urgent care request for medical Benefits is a special type of Prior Authorization that occurs when a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. Because your Provider is the one who initiates Prior Authorization, it will usually be your Provider who will request expedited processing. An urgent care request for medical Benefits will be decided as soon as possible, taking into account the medical exigencies, but no more than 72 hours after we receive your request. Urgent care requests for medical Benefits filed improperly or missing information may be denied.

If your pre-service or urgent care request for medical Benefits is denied, you will receive an explanation of why it was denied and how you can appeal (including how to request an expedited review).

## Timing of Appeals Determinations for Medical Claims

Separate schedules apply to the timing of medical Benefit requests and Claims appeals, depending on the type of request. There are four types of requests:

- **Urgent Care Request for Medical Benefits:** A request for Benefits provided in connection with urgent care services.
- **Concurrent Care Requests:** A request to extend an already approved ongoing course of treatment that was approved for a specific period of time or a specific number of treatments. If the request is urgent, we will follow the urgent care request for Benefits and appeals process. If it is not urgent, it will be treated like a new request for services and will follow the Pre-Service Request for Benefits and Appeal process.
- **Pre-Service Request for Medical Benefits:** A request for Benefits which the Bind Plan must approve or for which you must notify Bind before non-urgent care is provided.
- **Post-Service Claim Request for Medical Benefits:** A medical Claim for reimbursement of the cost of non-urgent care that has already been provided.

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

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

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

## Urgent Care Request for Medical Benefits and Appeal*

| Request for Urgent Care or Concurrent Care Benefits | Claims Timing |
|---|---|
| If your request for Benefits is incomplete, Bind must notify you within: | **24 hours** and advise you what information is needed |
| You must then provide a completed request for Benefits to Bind within: | **48 hours** after receiving notice of additional information required |
| Bind must notify you of the Benefit determination within: | **48 hours** of receiving the needed information |
| If your request for Benefits is complete when it is filed, Bind must notify you within: | **72 hours** |
| If Bind denies your request for Benefits, you must appeal an Adverse Benefit Determination no later than: | **180 days** after receiving the Adverse Benefit Determination |
| **Expedited Appeals (Urgent Care or Concurrent Care)** | **Appeals Timing** |
| Bind must notify you of the appeal decision within: | **72 hours** after receiving the appeal — if the appeal is still urgent. If services have already been provided, we follow the Post-service appeals process. |

*****Follow the procedure for an Expedited Appeal provided in your denial of coverage letter.

## Pre-Service Request for Medical Benefits and Appeal*

| Request for Pre-Service Benefits | Claims Timing |
|---|---|
| If your request for Benefits is filed improperly, Bind must notify you within: | **5 days** |
| If your request for Benefits is incomplete, Bind must notify you within: | **15 days** |
| You must then provide a completed request for Benefits information to Bind within: | **45 days** |
| Bind must notify you of the Benefit determination: | |
| • If the initial request for Benefits is complete, within: | **15 days** |
| • After receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within: | **15 days*** |
| *Bind may require a one-time extension for the request for Pre-Service Benefits, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Bind Plan. We will notify you if we determine that the additional time is needed before the 15 days expires. | |
| You must appeal an Adverse Benefit Determination no later than: | **180 days** after receiving the Adverse Benefit Determination |

| Appeals (Pre-Service) | Appeals Timing |
|---|---|
| Bind must notify you of the first-level appeal decision within: | **15 days** after receiving a complete first-level appeal |
| You must appeal the first-level appeal (file a second-level appeal) within: | **60 days** after receiving the first-level appeal decision |
| Bind must notify you of the second-level appeal decision within: | **15 days** after receiving a complete second-level appeal |

## Post-Service Claim Request for Medical Benefits and Appeal*

| Post-Service Claim | Claims Timing |
|---|---|
| If your medical Claim is incomplete, Bind must notify you within: | **30 days** |
| You must then provide completed medical claim information to Bind within: | **45 days** |
| Bind must notify you of the Benefit determination: | |
| • If the initial medical Claim is complete, within: | **30 days** |
| • After receiving the completed medical Claim (if the initial medical Claim is incomplete), within: | **30 days** |
| *Bind may require a one-time extension for the initial Post-Service Claim determination, of no more than 15 days, only if more time is needed due to circumstances beyond control of the Bind Plan. We will notify you if we determine that the additional time is needed before the 30 days expires. | |
| You must appeal an Adverse Benefit Determination no later than: | **180 days** after receiving the Adverse Benefit Determination |
| **Appeals (Post-Service)** | **Appeals Timing** |
| Bind must notify you of the first-level appeal decision within: | **30 days** after receiving the first-level appeal |
| You must appeal the first-level appeal (file a second-level appeal) within: | **60 days** after receiving the first-level appeal decision |
| Bind must notify you of the second-level appeal decision within: | **30 days** after receiving the second-level appeal |

## Concurrent Care Request for Medical Benefits

In some cases, you may have an ongoing course of treatment approved for a specific period of time or a specific number of treatments, and you may want to extend that course of treatment. This is called a Concurrent Care Claim.

If your extension request is not “urgent” (as defined in the previous section), your request will be considered a new request and will be decided according to the applicable procedures and timeframes. If your request for an extension is urgent you may request expedited processing.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. Bind will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If we inform you about our decision orally, we will follow up within three business days with a written or electronic notice.

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

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

If your Concurrent Care Claim is denied, you will receive an explanation of why it was denied and how you can appeal (including how to request expedited review). You may have the right to an external review through an Independent Review Organization (IRO) upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in decision letter to you from Bind.

## Notice of Medical Claim Denial on Appeal

If your medical Claim is denied on review, the reviewer will provide you with a notice of the Adverse Benefit Determination that will:

- Be written in a manner designed to be understood by an average individual and, where required by law, in a culturally and linguistically appropriate manner.
- Include information sufficient to identify the Claim involved (including the date of service, the health care Provider, and the Claim amount [if applicable]); you can also request from the reviewer the diagnosis and treatment codes and their explanation.
- Include the specific reasons for the Adverse Benefit Determination (including the denial code and its meaning and a description of the Plan's standard, if any, that was used in denying the Claim and a discussion of the decision).
- Refer to the specific Plan provisions on which the determination was based.
- Inform you that, upon request and free of charge, you are entitled to reasonable access to, and copies of, all documents, records, and other information relevant to the Claim for Benefits.
- Notify you of your right to bring legal action under ERISA.

- Include a copy of any internal rule, protocol or criterion that was relied on in making the determination or indicate that a copy of such material is available (free of charge) upon request.
- Either explain the scientific or clinical judgment made or indicate that such an explanation is available upon request, free of charge, if the determination was based on Medical Necessity or similar exclusion or limit.
- Contain a statement about the availability of contact information for any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes.
- A statement about any voluntary appeal procedures your Plan may offer.
- Notify you that you can contact the Department of Labor or State Insurance Regulatory Agency to learn about other voluntary alternative dispute resolution options.

The reviewer's decision on appeal is the final internal Adverse Benefit Determination.

## Federal External Review Program for Medical Claims

If, after exhausting your internal appeals, you are not satisfied with the determination made by Bind, you may be entitled to request an external review. The process is available at no charge to you.

You can also start the external review process without exhausting the internal appeals if Bind fails to follow the internal appeals process described above (unless it is a minor failure).

If one of the above conditions is met, you may request an external review of Adverse Benefit Determinations based upon any of the following:

- Medical judgement and/or Clinical reasons— for example Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered Benefit.
- A determination that a treatment, service, drug, or device is an Experimental or Investigational Service(s) or Unproven Service(s).
- Whether a Participant is entitled to a reasonable alternative standard for a reward under a wellness program.
- A determination as to whether a Plan is complying with non-quantitative mental health parity requirements.
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, call Bind Help or by sending a written request to the address set out in the determination letter. A request must be made within 120 days after the date you received the final internal Adverse Benefit Determination letter from Bind.

An external review request should include all of the following:

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

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

### Standard External Review for Medical Claims

A standard external review comprises of all of the following:

- A preliminary review by Bind of the request completed within five business days following Bind's receipt of the request.
- A referral of the request by Bind to the IRO.
- A decision by the IRO.

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

- Is or was covered under the Bind Plan at the time the health care service or procedure that is at issue in the request was provided.
- The denial does not relate to your eligibility to participate in the Plan.
- Has exhausted the applicable internal appeals process or is deemed to have exhausted the internal appeals process.
- Has provided all the information and forms required for Bind to process the request.

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

If the request is complete but not eligible for external review, Bind will provide notification that includes the reasons for ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete; you will have at least 48 hours (or, if longer, until the end of the four-month filing period) to complete the request.

The IRO will timely notify you in writing whether the request is eligible for external review. Within 10 business days following the date of receipt of the notice, you may submit in writing to the IRO

additional information for the IRO to consider in conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after 10 business days.

Bind will provide to the assigned IRO the documents and information considered in making the determination, including:

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

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

Upon receipt of a Final External Review Decision reversing the determination made by Bind, the Bind Plan will immediately provide coverage or payment for the Benefit Claim at issue in accordance with the terms and conditions of the Bind Plan, and any applicable law regarding Plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Bind Plan will not be obligated to provide Benefits for the health care service or procedure.

### Expedited External Review for Medical Claims

An expedited external review is similar to a standard external review. The time for completing the review process is much shorter, and in some instances, you may file an expedited external review before completing the internal appeals process.

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

- An Adverse Benefit Determination of a medical Claim or appeal if the Adverse Benefit Determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal.
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued

stay, or health care service, procedure, or product for which the individual received Emergency services, but has not been discharged from a facility.

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

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

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

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

**You may contact Bind Help for more information regarding external review rights, or if you are making a verbal request for an expedited external review.**

## Limitation of Action for Medical Claims

You cannot bring any legal action against the Plan Administrator or Claim Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your medical Claim have been completed. If you file your medical Claim within the required time and complete the entire medical Claim and appeals procedure, you must commence any lawsuit within six months after the medical Claim and appeals procedure is complete. In all events, you must commence the lawsuit within one year after the date you know or reasonably should know the principal facts upon which your medical Claim is based.

# 9. What are My Rights under ERISA?

## Statement of ERISA Rights

A Participant under the Bind Plan is entitled to certain rights and protections under ERISA, which provides that all Participants shall be entitled to:

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

### Continue Group Health Bind Plan Coverage

- Continue health care coverage for the employee or dependents if there is a loss of coverage under the Bind Plan as a result of a qualifying event. Participants may have to pay for such coverage. Review Section 10 (Continuation of Coverage) in this document and the Bind Plan rules governing COBRA continuation coverage rights.

### Prudent Actions by Bind Plan Fiduciaries

- In addition to creating rights for Bind Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Participants.
- No one, including the employer, a union, or any other person, may fire an employee or otherwise discriminate against an employee in any way to prevent him/her from obtaining a welfare benefit or exercising rights under ERISA.

### Enforce Rights

- If a Claim for a welfare benefit is denied or ignored, in whole or in part, a Participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules (see Section 8 [What Do I Do If My Claim Is Denied]).

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- Under ERISA, there are steps Participants can take to enforce the above rights. For instance, if a Participant requests a copy of Bind Plan documents or the latest annual report from this Plan and does not receive them within 30 days, the Participant may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Participant up to $110 a day until he/she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

- If a Participant has a Claim for Benefits that is denied or ignored, in whole or in part, the Participant may file suit in a state or Federal court after exhausting the appeal procedures provided in the Bind Plan (see Section 8 [What Do I Do If My Claim Is Denied]). In addition, if a Participant disagrees with the Bind Plan's decision or lack thereof concerning the qualified status of a medical child support order, the Participant may file suit in Federal court. If it should happen that Plan fiduciaries misuse this Plan's money, or if a Participant is discriminated against for asserting his/her rights, he/she may seek assistance from the U.S. Department of Labor or may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the Participant is successful, the court may order the person he/she has sued to pay these costs and fees. If the Participant loses, the court may order the Participant to pay these costs and fees — for example, if it finds the Claim is frivolous.

- Exhaustion of administrative procedures required. To the fullest extent permitted under applicable law, the right to maintain a court action is subject to the Plan's requirements that administrative procedures be completed first. This is called exhaustion of administrative remedies. Failure to exhaust administrative procedures may preclude you from bringing an action in court.

**Assistance with Questions**

- For questions about this Plan, contact the Plan Administrator.

- For questions about this statement or about a Participant's rights under ERISA, or if a Participant needs assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

- A Participant may also obtain certain publications about rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

# 10. Continuation of Coverage

## COBRA Continuation Coverage

If you lose your Bind coverage, you may have the right to extend it under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and as explained in the UHG, Inc. Benefit Handbook – Health Benefits.

- If your conditional coverage is still effective (within the 120 days since elected) and you elect COBRA, you may continue the conditional coverage under COBRA for the days remaining under your 120-day conditional coverage period. The remaining premiums due for the conditional coverage, will be recalculated to be paid on a monthly basis and will be collected by the COBRA vendor. Please contact Bind Help to find out more about COBRA for the conditional coverage and how premiums will be collected.
- If you elect to continue Bind coverage on COBRA, any outstanding premium you would owe for any conditional coverage purchases for you or any covered dependents would be added to your monthly COBRA bill until that amount is paid in full.
- If you have elected COBRA and choose to enroll in a conditional coverage, premiums for the conditional coverage will be calculated to be paid on a monthly basis and collected by the COBRA vendor. Please contact Bind Help to find out more about COBRA for the conditional coverage and how premiums will be collected.

# 11. What Else Do I Need to Know?

## 11.1 Important Administrative Information

| | |
|---|---|
| **Name of the Bind Plan** | UHG Inc. Group Benefits Plan |
| **Plan Sponsor** | UnitedHealth Group Incorporated is the Plan Sponsor of the UHG Inc. Group Benefits Plan.<br>The Plan Sponsor's mailing and street address for courier delivery is:<br>UnitedHealth Group Incorporated<br>c/o Corporate Benefits Department<br>MN008-R120<br>9900 Bren Road East<br>Minnetonka, MN 55343<br>The Plan Sponsor's phone number is: 1-952-936-1300 |
| **Plan Sponsor's Employer Identification Number (EIN)** | 41-1321939 |
| **Plan Number (from ERISA 5500 form)** | 530 |
| **Bind Coverage Plan Year** | 1/1/2021 through 12/31/2021 |
| **Agent for Legal Process** | If you wish to file suit, legal papers may be serviced on the UnitedHealth Group's Office of the General Counsel.<br>The agent's mailing and street address for courier delivery is:<br>Office of the General Counsel<br>UnitedHealth Group Incorporated<br>MN008-T700<br>9900 Bren Road East<br>Minnetonka, MN 55343<br>The agent's phone number is: 1-952-936-1300<br>Legal process can also be served on the Plan Administrator, through its Corporate Benefits Department at its mailing or courier delivery address. |
| **Type of Bind Plan** | Welfare benefit plan providing group health Benefits. |
| **Funding** | The Bind Plan is self-insured, meaning that Benefits are paid from the general assets of the Plan Sponsor and are not guaranteed under a Benefit policy or contract. The Plan Sponsor determines the amount of employee contributions to the Bind Plan, based on estimates of Claims and administrative costs. |
| **Plan Administrator** | The UnitedHealth Group Employee Benefits Plans Administrative Committee is the Plan Administrator of the UHG Inc. Group Benefits Plan.<br>The Plan Administrator's mailing and street address is:<br>UnitedHealth Group Employee Benefits Plans Administrative Committee<br>c/o Corporate Benefits Department<br>MN008-R120<br>9900 Bren Road East<br>Minnetonka, MN 55343<br>The Plan Administrator's phone number is: 1-952-936-1300 |

## 11.2 Coordination of Benefits

### Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Bind Plan will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the *National Association of Insurance Commissioners* (NAIC) and represents standard industry practice for coordinating Benefits.

### When Does Coordination of Benefits Apply?

This Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charge (defined below).

A Participant will need to elect and activate conditional coverages for this Plan regardless of whether this Plan is paying as primary or subsequent.

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

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

### Definitions

For purposes of this section, terms are defined as follows:

A. **Plan**. A Plan is any of the following that provides Benefits or services for medical, pharmacy, or dental care or treatment. If separate contracts are used to provide coordinated coverage for Participants of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

   1. Plan includes group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans, or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

2. Plan does not include hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **This Plan.** This Plan means, in a COB provision, the part of the contract providing the health care Benefits to which the COB provision applies, and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

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

D. **Allowable Expense.** Allowable Expense is a health care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or according to contractual agreement is prohibited from charging a Participant is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
2. If a person is covered by two or more Plans that compute their benefit payments on the basis of Usual and Customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of Usual and Customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its Benefits.
5. The amount of any benefit reduction by the Primary Plan because a Participant has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred Provider arrangements.

E. **Closed Panel Plan.** Closed Panel Plan is a Plan that provides health care benefits to Participants primarily in the form of services through a panel of Providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other Providers, except in cases of Emergency or referral by a panel member.

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

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

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

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying Plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

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

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

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

a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan.

(2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's Plan is the Primary Plan. This shall not apply with respect to any Plan Year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

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

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

(a) The Plan covering the custodial parent.

(b) The Plan covering the custodial parent's spouse.

(c) The Plan covering the non-custodial parent.

(d) The Plan covering the non-custodial parent's spouse.

c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

d) (i) For a dependent child who has coverage under either or both parents' Plans and also has his or her own coverage as a dependent under a spouse's Plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's Plan began on the same date as the dependent child's coverage under either or both parents' Plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee (i.e., an employee who is neither laid off nor retired), is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 2(d)(i) above can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, Participant, subscriber, or retiree or covering the person as a dependent of an employee, Participant, subscriber, or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 2(d)(i) above can determine the order of benefits.

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

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

## Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its Benefits so that the total Benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any Claim, the Secondary Plan will calculate the Benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the Claim do not exceed the total Allowable Expense for that Claim. In addition, the Secondary Plan shall credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

C. This Plan reduces its Benefits as described below for Participants who are eligible for Medicare when Medicare would be the Primary Plan.

   Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

   - The person is entitled but not enrolled in Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
   - The person is enrolled in a Medicare Advantage (Medicare Part C) Plan and receives non-Covered Health Services because the person did not follow all rules of that Plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
   - The person receives services from a Provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the Provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
   - The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or any other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.

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- The person is enrolled under a Plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

Important: If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under this coverage Plan), you should enroll for and maintain coverage under both Medicare Part A and Part B. If you do not enroll and maintain that coverage, and if we are secondary to Medicare, we will pay Benefits under this coverage Plan as if you were covered under both Medicare Part A and Part B. As a result, your out-of-pocket costs will be higher.

If you have not enrolled in Medicare, Benefits will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating Provider if either of the following applies:

- You are eligible for, but not enrolled in, Medicare and this coverage Plan is secondary to Medicare.
- You have enrolled in Medicare but choose to obtain services from a doctor that opts-out of the Medicare program.

When calculating this coverage Plan's Benefits in these situations for administrative convenience, we may, as we determine, treat the Provider's billed charges, rather than the Medicare-approved amount or Medicare limiting charge, as the Allowable Expense for both This Plan and Medicare.

## Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine Benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining Benefits payable under This Plan and other Plans covering the person claiming Benefits.

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

## Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

### Does This Plan Have the Right of Recovery?

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

### How Are Benefits Paid When This Plan is Secondary to Medicare?

If this Plan is secondary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits.

## 11.3 Subrogation, Overpayment and Reimbursement

### Subrogation and Refund

A Participant may incur medical expenses due to illness or injuries that may be caused by the act or omission of a Third Party. Also, a Third Party (such as an insurance company) may be responsible for payment on account of the actions of another person or entity. In such circumstances, the Participant may have a claim against the Third Party for payment of medical expenses. Accepting Benefits under the Plan/Bind Plan for those incurred medical expenses automatically assigns to the Plan/Bind Plan any rights the Participant may have to Recoveries from any Third Party up to the full amount of such Benefits. This Subrogation right allows the Plan/Bind Plan to pursue any claim that the Participant has against any Third Party, whether or not the Participant chooses to pursue that claim. The Plan/Bind Plan may make a claim directly against the Third Party, but in any event, the Plan/Bind Plan has an equitable lien on any amount of the Recovery of the Participant whether or not designated as payment for medical expenses. In addition, each Participant agrees to hold Recoveries in a constructive trust for the benefit of the Plan/Bind Plan. The equitable lien and constructive trust shall remain in effect until the Plan/Bind Plan is repaid in full. In the event that the Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a Third Party, the Plan's/Bind Plan's Subrogation and Refund rights shall still apply.

### Assignment of Interest and the Plan's/Bind Plan's Recovery Right

The Participant:

- Automatically assigns to the Plan/Bind Plan his or her rights against any Third Party when this provision applies.
- Must repay to the Plan/Bind Plan the Benefits paid on his or her behalf out of any Recovery.

Each Participant is individually obligated to comply with the provisions of this section. When a Participant receives or claims Plan/Bind Plan Benefits for an illness or injury caused by another, the Participant agrees to immediately reimburse the Plan/Bind Plan from any Recovery for Benefits paid out by the Plan/Bind Plan.

## Make Whole and Common Fund Doctrines Inapplicable

The Plan/Bind Plan expressly disavows and repudiates the make whole doctrine, which, if applicable, would prevent the Plan/Bind Plan from receiving a Recovery unless a Participant has been "made whole" with regard to illness or injury that is the responsibility of a Third Party. The Plan/Bind Plan also expressly disavows and repudiates the common fund doctrine, which, if applicable, would require the Plan/Bind Plan to pay a portion of the attorney fees and costs expended in obtaining a Recovery. These doctrines have no application to the Plan/Bind Plan since the Plan's/Bind Plan's Refund rights apply to the first dollars payable by a Third Party.

## Duty to Cooperate

Participants are required to cooperate with the Plan Administrator to effectuate the terms of this section. Specifically, it is the Participant's obligation at all times, both prior to and after payment of medical Benefits by the Plan/Bind Plan:

- To cooperate with the Plan/Bind Plan, or any representatives of the Plan/Bind Plan, in protecting the Plan's/Bind Plan's rights, including discovery, attending depositions, and/or cooperating at trial.
- Provide prompt notice to the Plan/Bind Plan when a claim is made against a party for illness or injury.
- To provide the Plan/Bind Plan with pertinent information regarding the illness, disease, disability, or injury, including accident reports, settlement information, and any other requested additional information.
- To take such action and execute such documents as the Plan/Bind Plan may require to facilitate enforcement of its Subrogation and reimbursement rights.
- To do nothing to prejudice the Plan's/Bind Plan's rights of Subrogation and Refund.
- To promptly reimburse the Plan/Bind Plan when a Recovery through settlement, judgment, award, or other payment is received.
- To not settle or release, without the prior consent of the Plan/Bind Plan, any claim to the extent that the Participant may have Recovery rights against any Third Party.

If the Participant and/or his or her attorney fails to reimburse the Plan/Bind Plan for all Benefits paid or to be paid from any Recovery, the Participant will be responsible for any and all expenses (including attorney fees and costs) associated with the Plan's/Bind Plan's attempt to Recover such money from the Participant or a Third Party.

## Conditions Precedent to Coverage

The Plan/Bind Plan shall have no obligation whatsoever to pay medical Benefits to a Participant if a Participant refuses to cooperate with the Plan's/Bind Plan's Subrogation and Refund rights or

refuses to execute and deliver such papers as the Plan/Bind Plan may require in furtherance of its Subrogation and Refund rights. Further, in the event the Participant is a minor, the Plan/Bind Plan shall have no obligation to pay any medical Benefits incurred on account of illness or injury caused by a Third Party until after the Participant or his or her authorized legal representative obtains valid court recognition and approval of the Plan's/Bind Plan's 100%, first-dollar Subrogation and Refund rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

## Other Coverage

When medical payments are available under other coverage, the Plan/Bind Plan shall always be considered secondary to such plans and/or policies. Other coverage shall include, but is not limited to:

- Any primary payer besides the Plan/Bind Plan.
- Any other group health plan.
- Any other coverage or policy covering the Participant.
- Any first-party insurance through medical payment coverage, personal injury protection, no-fault auto insurance coverage, uninsured or underinsured motorist coverage.
- Any policy of insurance from any insurance company or guarantor of a responsible party.
- Any policy of insurance from any insurance company or guarantor of a third party.
- Workers' compensation or other liability insurance company.
- Any other source including crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

## Offset

Failure by a Participant and/or his/her attorney to comply with any of the requirements described in this section may, at the Plan's/Bind Plan's discretion, result in a forfeiture of payment by the Plan/Bind Plan of future medical Benefits, and any funds or Benefits otherwise payable under the Plan/Bind Plan to or on behalf of the Participant may be withheld until the Participant satisfies his or her obligation.

## Defined Terms

The following terms have special meanings for purposes of this section:

- "Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid by a Third Party to, or on behalf of, a Participant by way of judgment, settlement, or otherwise to compensate for all losses caused by an illness or injury, whether or not said monies are characterized as medical expenses covered by the Plan/Bind Plan. "Recoveries" includes, but is not limited to,

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Recoveries for medical expenses, attorney's fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages, and any other Recovery of any form of damages or compensation whatsoever.

- "Refund" means repayment to the Plan/Bind Plan for medical Benefits that the Plan/Bind Plan has paid toward care and treatment of an illness or injury suffered by a Participant as the result of acts or omissions of a Third Party. This right of Refund includes Recoveries by a Participant under an uninsured or underinsured motorist insurance policy, homeowner's policy, renter's policy, medical malpractice policy, or any liability insurance policy (each of which will be treated as Third Party coverage under this article).
- "Subrogation" means the Plan's/Bind Plan's right to pursue and place a lien upon the Participant's claims for medical expenses against the other person.
- "Third Party" means any individual or entity (including an insurance company) who is legally obligated to pay a Recovery to, or on behalf of, a Participant.

## Erroneous Payments

To the extent payments made by the Plan/Bind Plan with respect to a Participant are in excess of the maximum amount of payment necessary under the terms of the Plan/Bind Plan, the Plan/Bind Plan shall have the right to Recover such payments, to the extent of such excess from any one or more of the following sources, as the Plan/Bind Plan shall determine any person to or with respect to whom such payments are made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan/Bind Plan determines are either responsible for payment or received payment in error, and any future Benefits payable to the Participant.

## Excess Insurance

Except as otherwise provided under Section 11.2 (Coordination of Benefits) the following rule applies:

- If there is available, or potentially available, any coverage (including coverage resulting from a judgment at law or settlements), the Benefits under the Plan/Bind Plan shall apply only as an excess over such other sources of coverage, except as otherwise provided for under Section 11.2 (Coordination of Benefits).
- The Plan's/Bind Plan's Benefits shall be excess to:
  - The responsible party, its insurer, or any other sources on behalf of that party.
  - Any first party insurance through medical payment coverage, personal injury protection, no-fault auto insurance coverage, uninsured or underinsured motorist coverage.
  - Any policy of insurance from any insurance company or guarantor of a Third Party.
  - Worker's compensation or other liability insurance company.
  - Any other source, including crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

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### Separation of Funds

Benefits paid by the Plan/Bind Plan, funds Recovered by the Participant(s), and funds held in trust over which the Plan/Bind Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s) or filing of bankruptcy by the Participant(s), will not affect the Plan's/Bind Plan's equitable lien, the funds over which the Plan/Bind Plan has a lien, or the Plan's/Bind Plan's right to Subrogation and reimbursement.

### Severability

In the event that any provision of this section is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining provisions of this section and the Plan/Bind Plan. The provision shall be fully severable. The Plan/Bind Plan shall be construed, and provisions enforced as if such invalid or illegal provision had never been inserted in the Plan/Bind Plan.

## 11.4 Plan Administrator's Responsibilities

The Plan Administrator and named fiduciary of the Plan is The UnitedHealth Group Employee Benefits Plans Administrative Committee.

The Plan Administrator has the authority and discretion to interpret the Plan's terms and Benefits under them, and to make factual and legal decisions about them. The Plan Administrator has the powers and duties of the general administration of this Plan, including the following:

- To administer the Plan in accordance with its terms.
- Interpret this SPD.
- Develop policies, practices, and procedures for this Plan.
- Administer the Plan in accordance with those policies, practices, and procedures.

The Plan Administrator will exercise its discretion and fulfill its responsibilities in accordance with the provisions of ERISA. The Plan Administrator may delegate some of its responsibilities to Bind or to the individuals or entities as appropriate. Bind may make fiduciary decisions in its role as Claims Administrator. It may also make ministerial and non-fiduciary decisions to facilitate Plan administration, including but not limited to, developing, interpreting, and relying upon policies, practices, and procedures for the administration of the Bind Plan, but is not financially responsible for Claims.

The Plan Administrator serves without compensation.

## 11.5 Other Information About Your Bind Plan

### Non-Discrimination Policy

This Plan will not discriminate against any Participant based on race, color, religion, national origin, disability, gender, sexual orientation, or age. This Plan will not establish rules for eligibility based on

health status, medical condition, Claims experience, receipt of health care, medical history, evidence of insurability, genetic information, or disability.

This Plan intends to be nondiscriminatory and to meet the requirements under applicable provisions of the Internal Revenue Code of 1986 (Code). If the Plan Administrator determines before or during any Plan Year that this Plan may fail to satisfy any nondiscrimination requirement imposed by the Code or any limitation on Benefits provided to highly compensated individuals, the Plan Administrator shall take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated covered employees, to ensure compliance with such requirements or limitation.

## Mental Health Parity

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity between covered health care Benefits and covered mental health and substance disorder Benefits relating to financial cost-sharing restrictions and treatment-duration limitations. For further details, please contact the Plan Administrator.

## Newborns' and Mothers' Health Protection Act (NMHPA)

Group health plans and health insurance issuers generally may not, under federal law, restrict Benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the Bind Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## Qualified Medical Child Support Order Procedures

The Bind Plan will provide Benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA Section 609(a) or National Medical Support Notice. If the Bind Plan receives a medical child support order for your child that instructs the Bind Plan to cover the child, the Plan Administrator will review it to determine that it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Bind Plan as your dependent, and the Bind Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator and/or located within the UnitedHealth Group Benefits Handbook.

## Women's Health and Cancer Rights Act of 1998 (WHCRA)

Your Bind Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides Benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema.

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## Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233) prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information. GINA expands on the provisions in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in a number of ways:

- Group health plans and health insurers cannot base health care premiums for plans or a group of similarly situated individuals on genetic information.
- Plans and insurers are prohibited from requesting or requiring an individual to undergo a genetic test.
- Plans and insurers are prohibited from collecting genetic information (including family history) prior to or in connection with enrollment, or for underwriting purposes.

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## 12. Glossary

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Bind Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Bind Plan.

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| **Adverse Benefit Determination** | An Adverse Benefit Determination is a denial, reduction of or a failure to provide or make payment, in whole or in part, for a Benefit, including those based on a determination of eligibility, application of utilization review, or Medical Necessity. |
| **Adverse Health Factor** | A new or deteriorating health or medical condition that coincides with the treatment(s) described as a specific conditional coverage (Section 5.3 (Conditional Coverages), and to which you must self-attest that you have as part of the election and activation process to activate conditional coverage Benefits. |
| **Annual Enrollment** | A period of time where eligible persons are able to enroll, disenroll, and make Bind Plan changes without a life status change or Adverse Health Factor. |
| **Authorized Representative** | A person you appoint to assist you in submitting a Claim or appealing a Claim denial. You will be required to designate your Authorized Representative in writing. This could also be a Provider for urgent care Claims and expedited appeals. The appointment of an Authorized Representative is revocable by you. |
| **Autism Spectrum Disorder** | A range of complex neurodevelopmental disorders, characterized by persistent deficits in social communication and interaction across multiple contexts, restricted repetitive patterns of behavior, interests, or activities, symptoms that are present in the early development period that cause clinically significant impairment in social, occupational, or other important areas of functioning and are not better explained by intellectual disability or global developmental delay. Such disorders are determined by criteria set forth in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association*. |
| **Benefits** | The health care services covered under the Bind Plan approved by the Plan Administrator as Covered Health Services, and as applicable, conditional coverage elected and activated by a Participant, as explained in this SPD and any amendments. |
| **Bind Plan** | Refers to the Bind personalized health plan as used in this SPD. |
| **Claim** | A request for Benefits made by a Participant or his/her Authorized Representative in accordance with the procedures described in this SPD. It includes Prior Authorization requests. |
| **Claim Administrator** | Processes medical Claims and administers medical appeals as may be delegated for the Bind Plan. |
| **COBRA** | The Consolidated Omnibus Budget Reconciliation Act of 1985 as amended from time to time. A federal law that requires employers to offer continued health insurance coverage to certain Employees/Retirees and their covered dependents whose group health insurance has been terminated. |
| **Continuity of Care** | The option for existing Participants to request continued care from their current health care professional if he or she is no longer working with their health plan and is now considered out-of-network. |
| **Cosmetic** | Services, medications, and procedures that improve physical appearance but do not correct or improve a physiological function or are not Medically Necessary. |

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| **Covered Health Service** | Health care services that are Medically Necessary, provided by your Provider or clinic, and are covered by the Bind Plan, and as applicable, conditional coverages that have been elected and activated by a Participant, subject to all of the terms, conditions, limitations, and exclusions. |
| **Custodial Care** | Services to assist in activities of daily living and personal care that do not seek to cure or do not need to be provided or directed by a skilled medical professional, such as assistance in walking, bathing, and feeding. |
| **Domiciliary Care** | Living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services. |
| **Effective Date** | The date your coverage under the Bind Plan is effective, as described in Section 4. |
| **Eligible Charge** | A charge for health care services, subject to all of the terms, conditions, limitations, and exclusions for which the Bind Plan will pay. |
| **Eligible Expenses** | Charges for Covered Health Services that are provided while the Bind Plan is in effect and determined by the Claims Administrator.<br>Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator's discretion, following evaluation and validation of all Provider billings in accordance with one or more of the following methodologies:<br>• 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).<br>• As reported by generally recognized professionals or publications.<br>• As used for Medicare.<br>• As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.<br>Network Providers are reimbursed based on contracted rates. Out-of-network Providers are reimbursed at a percentage of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.<br>**Note:** Out-of-network Providers may bill you for any difference between the Provider's billed charges and the Eligible Expense described above. |
| **Emergency** | The sudden onset or change of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected by a prudent layperson to result in:<br>1. Placing the Participant's health in serious jeopardy.<br>2. Serious impairment to bodily functions.<br>3. Serious dysfunction of any bodily organ or part. |
| **ERISA** | The Employee Retirement Income Security Act of 1974 as amended from time to time. |
| **E-Visit and Telephone Consult with Your Physician after an Emergency Room Visit** | Care provided by designated participating Providers performed without physical face to face interaction, but through electronic (including telephonic) communication through an online portal or telephone. |

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| **Experimental / Investigational Services** | A procedure, study, test, drug, equipment, or supply will be considered Experimental and/or Investigational if it is not covered under Bind Coverage with Evidence Development Policy and any of the following criteria/guidelines is met:<br>• It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum tolerated dose, or effectiveness in comparison to conventional treatments.<br>• It is being delivered or should be delivered subject to approval and supervision of an institutional review board (IRB) as required and defined by federal regulations or other official actions (especially those of the FDA or DHHS).<br>• Other facilities/Providers/etc. studying substantially the same drug, device, medical treatment, or procedure refer to it as Experimental or as a research project, a study, an invention, a test, a trial, or other words of similar effect.<br>• The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings.<br>• It is not Experimental or Investigational itself pursuant to the above criteria but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that is Experimental or Investigational (e.g., lab tests or imaging ordered to evaluate the effectiveness of an Experimental therapy).<br>• It cannot lawfully be marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use.<br>• It is a subject of a current investigation of new drug or new device (IND) application on file with the FDA.<br>• It is the subject of an ongoing Clinical Trial (Phase I, II or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and Department of Health and Human Services (DHHS).<br>• It is being used for off-label therapies for a non-indicated condition – even if FDA approve for another condition. |
| **Explanation of Benefits (EOB)** | The EOB provides details about a Claim and explains what portion was paid to the Provider and what portion (if any) is the Participant's responsibility. The EOB is not a bill, it is a statement provided by the Claims Administrator to you, your Physician, or another health care professional that explains the Benefits provided (if any); the allowable reimbursement amounts; copayments; any other reductions taken; the net amount paid by the Bind Plan; and the reason(s) why the service or supply was not covered by the Bind Plan. |

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| **Medically Necessary / Medical Necessity** | A health care service is deemed Medically Necessary when it is delivered or supervised by a licensed health care Provider acting within the scope of the Provider's license according to the current standard of care, and is generally considered safe and effective for the prevention, diagnosis, or treatment of a covered health condition, as indicated by it being:<br>• Supported by two or more high-quality clinical trials published in peer-reviewed journals.<br>• Consistent with Physician and Health Care Provider Specialty Society recommendations and the view of Physicians and health care Providers practicing in relevant clinical areas.<br>• Consistent with clinical guidelines generally accepted in practice.<br>• Clinically appropriate — type, frequency, site, extent, and duration of service must be appropriate for you as an individual.<br>• Cost effective — services must not be more costly than alternative services that are at least as likely to produce equivalent therapeutic and diagnostic results.<br>• Not primarily for the convenience of the patient, health care Provider or other Physicians.<br>• Or covered under a Bind Coverage with Evidence Development Policy.<br>Bind ensures Medical Necessity through Utilization Management processes. |
| **Observation Stay** | Observation care consists of evaluation, treatment, and monitoring services (beyond the scope of the usual outpatient care episode) that are reasonable and necessary to determine whether the patient will require further treatment as an inpatient or can be discharged from the hospital. |
| **Participant** | The eligible employee or dependent properly enrolled in the Bind Plan, and eligible for conditional coverages, under the eligibility rules and only while such person(s) is enrolled and eligible for Benefits under the Bind Plan. |
| **Pharmacy Benefit Manager (PBM)** | A third-party administrator of prescription drug programs for commercial health plans and self-insured employer plans. OptumRx is the PBM for the Bind Plan. |
| **Pharmacy Claims Administrator** | Also known as the Pharmacy Benefit Manager, or PBM, which provides administrative services for the Plan Administrator in connection with the operation of the pharmacy plan, including processing of Claims, as may be delegated to it. |
| **Physician** | Any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.<br>Any podiatrist, dentist, psychologist, chiropractor, optometrist or other Provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a Provider is described as a Physician does not mean that Benefits for services from that Provider are available to you under the Bind Plan. |
| **Plan** | UHG Inc. Group Benefits Plan. |
| **Plan Administrator** | The person or entity, as defined under Section (3)(16) of ERISA, that has the exclusive, final, and binding discretionary authority to administer the Bind Plan, to make factual determinations, to construe and interpret the terms of the SPD, the Bind Plan, and amendments (including ambiguous terms), and to interpret, review and determine the availability or denial of Benefits. The Plan Administrator may delegate discretionary authority and may employ or contract with individuals or entities to perform day-to-day functions, such as processing Claims and performing other Bind Plan-connected administrative services. |
| **Plan Sponsor** | The entity that establishes and maintains the Bind Plan, has the authority to amend and/or terminate the Bind Plan and is responsible for providing funds for the payment of Benefits. |
| **Plan Year** | January 1 through December 31 |

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| **Pre-Admission Notification** | Process whereby the Provider or you inform the Bind Plan that you will be admitted to the inpatient hospital, Skilled Nursing Facility, long term acute care facility, inpatient rehabilitation facility, partial hospitalization, or Residential Treatment Facility. This notice is required in advance of being admitted for inpatient care for any type of non-Emergency admission and for partial hospitalization. All contracted facilities are required to provide Pre-Admission Notification to you. |
| **Prior Authorization** | Pre-service, urgent care request, concurrent care benefit coverage decision for a service, procedure, or test that has been subject to an evidence-based review resulting in a Medical Necessity determination. |
| **Private Duty Nursing** | Nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or an office/home setting when any of the following are true:<br>• No skilled services are identified.<br>• Skilled nursing resources are available in the facility.<br>• The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.<br>• The service is provided to a Participant by an independent nurse who is hired directly by the Participant 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. |
| **Provider** | A health care professional, Physician, clinic, or facility licensed, certified, or otherwise qualified under applicable state law to provide health care services to you. The term "Provider" refers to an in-network Provider unless otherwise specified. |
| **Reconstructive** | Surgery or procedure to restore or correct:<br>• A defective body part when such defect is incidental to or follows surgery resulting from illness, injury, or other diseases of the involved body part.<br>• A congenital disease or anomaly which has resulted in a functional defect as determined by a Physician.<br>• A physical defect that directly adversely affects the physical health of a body part, and the restoration or correction is determined by the Claim Administrator to be Medically Necessary. |
| **Residential Treatment Facility** | A facility that is licensed by the appropriate state agency, has, or maintains a written, specific, and detailed treatment program requiring full-time residence and participation, and provides 24-hour-a-day care in a structured setting, supervision, food, lodging, rehabilitation, or treatment for an illness related to mental health and substance use related disorders. |
| **Shared Savings Program** | A program in which the network partner may obtain a discount to a non-network Provider's billed charges. This discount is usually based on a schedule previously agreed to by the non-network Provider. When this happens, you may experience lower out-of-pocket amounts. Bind Plan out-of-network copayments would still apply to the reduced charge. Sometimes the Bind Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by the network partner, such as a percentage of the published rates allowed by the *Centers for Medicare and Medicaid Services* (CMS) for the same or similar service within the geographic market, an amount determined based on available data resources of competitive fees in that geographic area, a fee schedule established by a third party vendor, or a negotiated rate with the Provider. In this case the non-network Provider may bill you for the difference between the billed amount and the rate determined by the network partner. If this happens you should call the number on your medical member ID Card. Shared Savings Program Providers are not network Providers and are not credentialed by the network partner. |

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| **Skilled Nursing Facility** | A Medicare licensed bed or facility (including an extended care facility, a long-term acute care facility, a hospital swing-bed, and a transitional care unit) that provides skilled care. |
| **Specialist** | Providers other than those practicing in the areas of family practice, general practice, internal medicine, OB/GYN or pediatrics. |
| **Specialty Drugs** | Infusions, injectables and non-injectable prescription drugs, as determined by the Claim Administrator, which have one or more of the following key characteristics:<br>• Frequent dosing adjustments and intensive clinical monitoring are required to decrease the potential for drug toxicity and to increase the probability for beneficial outcomes.<br>• Intensive patient training and compliance assistance are required to facilitate therapeutic goals.<br>• There is limited or exclusive product availability and/or distribution.<br>• There are specialized product handling and/or administration requirements.<br>• Are produced by living organisms or their products. |
| **Summary Plan Description (SPD)** | The document describing, among other things, the Benefits offered under the UHG Inc. Group Benefits Plan and your rights and obligations under such benefit option as required by ERISA. |
| **Telehealth Visit** | A visit with a Provider who uses a secure audio-video or audio-only telecommunications system allowing evaluation, assessment, and management of health care services. |
| **Transition of Care** | The option for a new Participant to request coverage from your current, out-of-network health care professional at in-network rates for a limited time due to a specific medical condition, until the safe transfer to an in-network health care professional can be arranged. |
| **Unproven / Unproven Services** | Health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:<br>• Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment isreceived.<br>• 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.<br>Bind has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time Bind issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can contact Bind Help for additional information.<br>**Please note:** If you have a life-threatening illness or condition (one that is likely to cause death within one year of the request for treatment), Bind may, at its discretion, consider an otherwise Unproven service to be a Covered Health Service for that illness or condition. Prior to such a consideration, Bind must first establish that there is sufficient evidence to conclude that, albeit Unproven, the service has significant potential as an effective treatment for that illness or condition. |
| **Usual and Customary** | The amount allowed for a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service. The Usual and Customary amount is used to determine the amount that may be charged by a Provider for the Benefits. |

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| **Utilization Management** | Utilization Management processes are conducted by Bind to ensure that certain services are Medically Necessary. Utilization Management processes include clinical, medical, pre-service review (e.g., Prior Authorization), concurrent review (e.g., during a hospital stay), and post-service review (review of Claims to ensure services were Medically Necessary). |

# 13. Attachments

## Attachment I – Outpatient Prescription Drugs

The Prescription Drug Benefit is administered by OptumRx.

**What this section includes:**

- Benefits available for Prescription Drug Products.
- How to utilize the retail and mail order service for obtaining Prescription Drug Products.
- Any Benefit limitations and exclusions that exist for Prescription Drug Products.
- Definitions of terms used throughout this section related to the Prescription Drug Product Plan.

### Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments or other payments that vary depending on which of the tiers of the Prescription Drug List (PDL) the Prescription Drug Product is listed. Refer to the Outpatient Prescription Drug Schedule of Benefits for applicable Copayment requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

Infusion services for immune globulin and inflammatory medications administered in the home or at an ambulatory infusion location by a home infusion Provider will need to be administered by Optum Infusion Pharmacy to be considered a covered service. Please call the Benefits Advocate at 1-844-585-1466 with questions.

### What You Must Pay

You are responsible for paying the applicable Copayment described in the Schedule of Benefits - Outpatient Prescription Drugs, in addition to any Ancillary Charge. You are not responsible for paying a Copayment for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your request and there is another drug that is Chemically Equivalent.

The amount you pay for any of the following under this section will not be included in calculating any out-of-pocket maximum stated in your SPD:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and OptumRx contracted rates (Prescription Drug Charge) will not be available to you.

## Payment Terms and Features - Outpatient Prescription Drugs

### Prescription Drug Product Coverage Highlights

The table below provides an overview of the Plan's Prescription Drug Product coverage. It includes Copayment amounts that apply when you have a prescription filled at a Network Pharmacy. For detailed descriptions of your Benefits, refer to Retail and Mail Order in this section.

**Note:** The out-of-pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 5 (What Are My Benefits).

### If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug Product becomes available as a Generic drug, the tier placement of the Brand-name Prescription Drug Product may change, and an Ancillary Charge may apply. As a result, your Copayment may change. You will pay the Copayment applicable for the tier to which the Prescription Drug Product is assigned.

### Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to obtain Prior Authorization from OptumRx or its designee. The reason for obtaining Prior Authorization from OptumRx or its designee is to determine if the Prescription Drug Product, in accordance with OptumRx's approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service as defined by the Plan.
- It is not an Experimental or Investigational or Unproven Service, as defined in Section 12 (Glossary).

The Plan may also require you to obtain Prior Authorization from OptumRx or its designee so OptumRx can determine whether the Prescription Drug Product, in accordance with OptumRx's approved guidelines, was prescribed by a Specialist Physician.

### Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing Provider, the pharmacist, or you are responsible for obtaining Prior Authorization from OptumRx.

If you do not obtain Prior Authorization from OptumRx before the Prescription Drug Product is dispensed, you can ask OptumRx to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from the Plan as described in Section Identification Card (ID Card) - Network Pharmacy below.

When you submit a Claim on this basis, you may pay more because you did not obtain Prior Authorization from OptumRx before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and any Ancillary Charge that applies.

To determine if a Prescription Drug Product requires Prior Authorization, either visit www.optum.com or call the number on your ID card. The Prescription Drug Products requiring Prior Authorization are subject to OptumRx's periodic review and modification.

Benefits may not be available for the Prescription Drug Product after OptumRx reviews the documentation provided and determines that the Prescription Drug Product is not a Covered Health Service, or it is an Experimental or Investigational or Unproven Service.

OptumRx 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 at www.optum.com or by calling the number on your ID card.

## Schedule of Benefits - Outpatient Prescription Drugs

### Benefit Information for Prescription Drug Products at a Network Pharmacy

| **Benefit[1,2]**<br>**Description and Supply Limits** | **Copayment of Prescription Drug Charge Payable by the member:**<br>**(Per Prescription Order or Refill):** |
|---|---|
| Your Copayment is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List (PDL) are assigned to Tier 1, Tier 2, Tier 3, or Tier 4. Please access www.optum.com or call the telephone number on your ID card to determine tier status. | |
| **Prescription Drug Products on the Prescription Drug Lists - Retail**<br>The following supply limits apply:<br>As written by the Provider, up to a consecutive 34-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.<br>A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment for each cycle supplied.<br>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 34-day supply, the Copayment that applies will reflect the number of days dispensed. | 100% after you pay a:<br>• Tier-1 $15 Copayment<br>• Tier-2 $40 Copayment<br>• Tier-3 $85 Copayment<br>• Tier-4 $300 Copayment |

| Benefit[1,2]<br>Description and Supply Limits | Copayment of Prescription Drug Charge Payable by the member:<br>(Per Prescription Order or Refill): |
|---|---|
| **Prescription Drug Products on the Prescription Drug Lists - Mail Order Network Pharmacy**<br>The following supply limits apply:<br>As written by the Provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.<br>The Plan may allow a 34-day fill at the Mail Order Pharmacy for certain Prescription Drug Products for the Copayment you would pay at a retail Network Pharmacy. You may determine whether a 34-day fill of Prescription Drug Product is available through the Mail Order Pharmacy for a retail Network Pharmacy Copayment at www.optum.com or by calling the telephone number on your ID card.<br>• Tier-1<br>• Tier-2<br>• Tier-3<br>• Tier-4 | 100% after you pay a:<br>$35 Copayment<br>$90 Copayment<br>$190 Copayment<br>$750 Copayment |
| **Level2 Enhanced Drug Benefit**<br>Members participating in the Level2 type 2 diabetes program have the opportunity to earn any enhanced drug benefit for certain diabetic medications and supplies at a $0 cost. For details on the program and criteria to earn this enhanced drug benefit, please see Section 13 Attachment V. | |

[1]Please obtain Prior Authorization from OptumRx before receiving Prescription Drug Products, as described in Payment Terms and Features, under Prior Authorization Requirements in this section.

[2]You are not responsible for paying a Copayment for Preventive Care Medications.

**Note:** The Coordination of Benefits provision described in Section 11.2 (Coordination of Benefits [COB]) applies to covered Prescription Drug Products as described in this section. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in this SPD.

### Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by OptumRx during regular business hours.

If you do not show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy and submit to the below address for reimbursement.

When you submit a Claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and any Ancillary Charge that applies.

Submit your Claim to:
OptumRx Claims Department
PO Box 650540
Dallas, TX 75265-0540

### Benefit Levels

Benefits are available for outpatient Prescription Drug Products that are considered Covered Health Services.

The Plan provides Benefits at different levels for tier-1, tier-2, tier-3, and tier-4 Prescription Drug Products.

All Prescription Drug Products covered by the Plan are categorized into these four tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Since the PDL may change periodically, you can visit www.optum.com or call OptumRx at the number on your ID card for the most current information.

Each tier is assigned a Copayment, which is the amount you pay when you visit the pharmacy or order your medications through mail order. Your Copayment will also depend on whether or not you visit the pharmacy or use the mail order service — see the table shown at the beginning of this section for further details. Here is how the tier system works:

- For the lowest out-of-pocket expense, you should consider tier-1 drugs if you and your Physician decide they are appropriate for your treatment.
- Consider a tier-2 drug if no tier-1 drug is available to treat your condition.
- The drugs in tier-3 are usually more costly. Sometimes there are alternatives available in tier-1 or tier-2.

- Tier 4 drugs have the highest costs. Most Tier 4 drugs have a Tier 1, Tier 2 or Tier 3 lower cost option.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of:

- The applicable Copayment.
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug.
- The Prescription Drug Charge for that Prescription Drug Product.

For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of:

- The applicable Copayment.
- The Prescription Drug Charge for that particular Prescription Drug.

**Retail**

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy. The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting OptumRx at the number on your ID card or by logging onto www.optum.com.

To obtain your prescription from a Network Pharmacy, simply present your ID card and pay the Copayment. The following supply limits apply:

- As written by the Provider, up to a consecutive 34-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.
- A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay the Copayment for each cycle supplied.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 34-day supply, the Copayment that applies will reflect the number of days dispensed.

If you purchase a Prescription Drug from a non-Network Pharmacy, you will be required to pay full price and will not receive reimbursement under the Plan.

**Note:** Network Pharmacy Benefits apply only if your prescription is for a Covered Health Service, and not for Experimental or Investigational, or Unproven Services. Otherwise, you are responsible for paying 100% of the cost.

### Mail Order

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy. The mail order service may allow you to purchase up to a 90-day supply of a covered Prescription Drug Product through the mail from a Network Pharmacy.

To use the mail order service, all you need to do is complete a patient profile and enclose your Prescription Order or Refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received. If you need a patient profile form, or if you have any questions, you can reach OptumRx at the number on your ID card.

The following supply limits apply: As written by the Provider, up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.

You may be required to fill an initial Prescription Drug Product order and obtain one refill through a retail pharmacy prior to using a mail order Network Pharmacy.

**Note:** To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged the mail order Copayment for any Prescription Order or Refill if you use the mail order service, regardless of the number of days' supply that is written on the order or refill. Be sure your Physician writes your mail order or refill for a 90-day supply, not a 34-day supply with three refills.

### Benefits for Preventive Care Medications

Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined, in this section, under Glossary - Prescription Drug Products. You may determine whether a drug is a Preventive Care Medication at www.optum.com or by calling OptumRx at the number on your ID card.

### Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, OptumRx may direct you to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Prescription Drug Product.

### Smart Fill Program - Split Fill

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Copayment. The Participant will receive a 15-day supply of their Specialty Prescription Drug Product to determine if they will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact the Participant each time prior to dispensing the 15-day supply to confirm if the Participant is tolerating the Specialty Prescription Drug Product. You may find a list of Specialty Prescription Drug

Products included in the Smart Fill Program, at www.optum.com or by calling the telephone number on your ID card.

**Specialty Prescription Drug Products (Tier-4)**

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, OptumRx may direct you to a Designated Pharmacy with whom OptumRx has an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Specialty Prescription Drug Product.

Please see Glossary - Outpatient Prescription Drugs, for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

**Want to lower your out-of-pocket Prescription Drug Product costs?**
Consider tier-1 Prescription Drug Products if you and your Physician decide they are appropriate.

**Assigning Prescription Drug Products to the Prescription Drug List (PDL)**

OptumRx's Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on OptumRx's behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety, or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or Prior Authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are most cost effective for specific indications as compared to others, therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

The PDL Management Committee may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Participants as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Participant is a determination that is made by the Participant and the prescribing Physician.

**Note**: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access www.optum.com or call the number on your ID card for the most up-to-date tier status.

Prescription Drug Product, Prescription Drug List (PDL), and Prescription Drug List (PDL) Management Committee are defined at the end of this section.

**Prescription Drug List (PDL)**
The Prescription Drug List (PDL) is a tool that helps guide you and your Physician in choosing the medications that allow the most effective and affordable use of your Prescription Drug Benefit.

### Prescription Drug Benefit Claims

For Prescription Drug Product Claims procedures, please refer to the above section, Identification Card (ID Card).

### Limitation on Selection of Pharmacies

If OptumRx determines that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, OptumRx may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you do not make a selection within 31 days of the date the Plan Administrator notifies you, OptumRx will select a single Network Pharmacy for you.

### Supply Limits

Benefits for Prescription Drug Products are subject to supply limits that are stated in the table under the heading Prescription Drug Product Coverage Highlights. For a single Copayment you may receive a Prescription Drug Product up to the stated supply limit. Whether or not a Prescription Drug Product has a supply limit is subject to OptumRx's periodic review and modification.

**Note:** Some products are subject to additional supply limits based on criteria that the Plan Administrator and OptumRx have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing, at www.optum.com or by calling the telephone number on your ID card.

### Special Programs

Certain programs may allow you to receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health

management programs. You may access information on these programs at www.optum.com or by calling the number on the back of your ID card.

**Prescription Drug Products Prescribed by a Specialist Physician**

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction, or no Benefit at www.optum.com or by calling the telephone number on your ID card.

**Step Therapy**

Certain Prescription Drug Products for which Benefits are described in this section are subject to Step Therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first.

You may determine whether a particular Prescription Drug Product is subject to Step Therapy requirements by visiting www.optum.com or by calling the number on the back of your ID card.

**Prescription Drug Products that are Chemically Equivalent**

If two drugs are Chemically Equivalent (they contain the same active ingredient) and you or your Physician choose not to substitute for this lower priced Chemically Equivalent drug for the higher priced drug, you will pay the difference between the higher priced drug and the lower priced Chemically Equivalent drug, in addition to the Copayment. This difference in cost is called an Ancillary Charge. An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the Provider's request and there is another drug that is chemically the same available at a lower price.

**Rebates and Other Discounts**

OptumRx and the Plan may, at times, receive rebates for certain drugs included on the PDL, including those drugs that you purchase prior to paying any Copayment. As determined by OptumRx, the Plan may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Copayment.

OptumRx and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this Outpatient Prescription Drug section.

Such business may include, but is not limited to, data collection, consulting, educational grants, and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Outpatient Prescription Drug section. OptumRx is not required to pass on to you, and does not pass on to you, such amounts.

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### Coupons, Incentives and Other Communications

At various times, OptumRx may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-Prescription Drug Products. These communications may include offers that enable you, at your discretion, to purchase the described product at a discount. In some instances, non-OptumRx entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

## Exclusions - What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed in Section 6 (What is Not Covered) also apply to this section. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can access www.optum.com or by calling the number on your ID card for information on which Prescription Drug Products are excluded.

1. For any condition, injury, sickness, or mental illness arising out of, or in the course of, employment for which Benefits are available under any workers' compensation law or other similar laws, whether or not a Claim for such Benefits is made, or payment of Benefits are received.
2. Any Prescription Drug Product for which payment or Benefits are provided or available from the local, state, or federal government (for example Medicare) whether or not payment or Benefits are received, except as otherwise provided by law.
3. Pharmaceutical Products for which Benefits are provided in the medical (not in Attachment I - Outpatient Prescription Drugs) portion of the Plan.
   - This exclusion does not apply to Depo Provera and other injectable drugs used for contraception. This exclusion does not apply to immunizations administered in a Network or a Designated Pharmacy.
4. Available over-the-counter medications that do not require a Prescription Order or Refill by federal or state law before being dispensed unless the Plan Administrator has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent.
   - Certain Prescription Drug Products that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

5. Compounded drugs that contain certain bulk chemicals. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to the highest cost tier.) Compounded drugs that are available as a similar commercially available Prescription Drug Product.
6. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.
7. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your SPD. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
8. Certain Prescription Drug Products for tobacco cessation.
9. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
10. The amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
11. The amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
12. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.
13. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Claims Administrator's Prescription Drug List (PDL) Management Committee.
14. Prescribed, dispensed, or intended for use during an Inpatient Stay.
15. Prescribed, dispensed for appetite suppression, and other weight loss products.
16. Prescribed to treat Infertility.
17. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that OptumRx and the Plan Administrator determines do not meet the definition of a Covered Health Service.
18. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
19. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
20. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by OptumRx. Such determinations may be made up to six times during a calendar year, and OptumRx may

decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

21. Certain unit dose packaging or repackagers of Prescription Drug Products.
22. Used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless OptumRx and the Plan Administrator have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in Section 12 (Glossary).
23. Used for Cosmetic purposes.
24. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken, or destroyed.
25. General vitamins, except for the following which require a Prescription Order or Refill:
    - Prenatal vitamins.
    - Vitamins with fluoride.
    - Single entity vitamins.
26. 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.
27. A Prescription Drug Product that contains marijuana, including medical marijuana.
28. Dental products, including but not limited to prescription fluoride topicals.
29. A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
30. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
31. Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

## Glossary - Outpatient Prescription Drugs

Ancillary Charge - a charge, in addition to the Copayment, that you are required to pay when a covered Prescription Drug Product is dispensed at your request, when a Chemically Equivalent

Prescription Drug Product is available. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Product Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product, and the Prescription Drug Product Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product.

**Brand-name** - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that OptumRx identifies as a Brand-name product, based on available data resources including, but not limited to, Medi-span or First DataBank, that classify drugs as either brand or Generic based on a number of factors. You should know that all products identified as a "Brand-name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by OptumRx.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with OptumRx or with an organization contracting on its behalf, to provide specific Prescription Drug Products including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that OptumRx identifies as a Generic product based on available data resources including, but not limited to, Medi-span or First DataBank, that classify drugs as either brand or Generic based on a number of factors. You should know that all products identified as a "Generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by OptumRx.

Infertility - failure to achieve a Pregnancy after a year of regular unprotected intercourse if the woman is under age 35, or after six months if the woman is over age 35. In addition, in order to be eligible for Benefits, the Participant must also:

- Be under age 44, if female.
- Have Infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.

Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that OptumRx establishes. This list is subject to OptumRx's periodic review and modification.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with OptumRx or an organization contracting on its behalf to provide Prescription Drug Products to Participants.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by OptumRx as a Network Pharmacy.

**New Prescription Drug Product** - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by OptumRx's Prescription Drug List (PDL) Management Committee.
- December 31st of the following calendar year.

Prescription Drug Charge - the rate the Plan has agreed to pay OptumRx on behalf of its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List (PDL) - a list that categorizes into tiers medications or products that have been approved by the *U.S. Food and Drug Administration*. This list is subject to OptumRx's periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned by contacting OptumRx at the number on your ID card or by logging onto www.optum.com.

Prescription Drug List (PDL) Management Committee - the committee that OptumRx designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of Benefits under this Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - Standard insulin syringes with needles.
  - Blood-testing strips - glucose.
  - Urine-testing strips - glucose.
  - Ketone-testing strips and tablets.
  - Lancets and lancet devices.
  - Glucose meters including continuous glucose monitors.
  - Certain vaccines/immunizations administered in a Network Pharmacy.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care Provider whose scope of practice permits issuing such a directive.

**Preventive Care Medications (PPACA Zero Cost Share)** – the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment) as required by applicable law under any of the following:

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

You may determine whether a drug is a Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives through the internet at www.optum.com or by calling OptumRx at the telephone number on your ID card.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products include certain drugs for Infertility. You may access a complete list of Specialty Prescription Drug Products at www.optum.com or by calling the number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

## Attachment II – NurseLine℠

NurseLine℠ is a telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information to help you make more informed health care decisions. When you call, a registered nurse may refer you to any additional resources that Participants have available that may help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- A recent diagnosis.
- A minor sickness or injury.
- Men's, women's, and children's wellness.
- How to take prescription drug products safely.
- Self-care tips and treatment options.
- Healthy living habits.
- Any other health related topic.

NurseLine℠ gives you another way to access health information. By calling the same number, you can listen to one of the Health Information Library's many recorded messages (more than 1,100 recorded messages, with over half in Spanish).

NurseLine℠ is available to you at no additional cost. To use this service, simply call 1-800-705-0821.

***Note:*** *If you have a medical Emergency, call 911 instead of calling NurseLine℠.*

With NurseLine℠, you also have access to nurses online. To use this service, log onto www.optum.com where you may access the link to initiate an online chat with a registered nurse who can help answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

***Note:*** *If you have a medical Emergency, call 911 instead of calling NurseLine℠.*

## Attachment III – Real Appeal Weight Loss Program

Maintaining a healthy weight is an important element of everyone's health. The Real Appeal program is geared to people who meet certain BMI requirements who want to make lasting weight loss changes.

For those who qualify, the program is free of charge.

**Key Program Features**

How It Works:

- The Real Appeal weight-loss program is a step-by-step, guided program personalized to each Participant. The program provides tools, information and ongoing support and guidance aimed at helping people achieve their weight loss goals.

What you will receive:

- Personalized coaching with up to a year of support, 24/7 online access to support and progress tracking via a mobile app, and a welcome kit that includes a weight and food scale, exercise DVDs, food guides and more.

To learn more about Real Appeal, call 844-924-7325.

**How to Enroll:**

To enroll, go to: Rally Coach - Register (werally.com)

## Attachment IV - UnitedHealthcare Hearing

UnitedHealthcare Hearing helps make hearing health care more accessible and affordable by offering innovative hearing solutions that deliver choice, convenience, and value to you and your families. UnitedHealthcare Hearing assists you with locating a network Provider for a routine hearing test and consultation, hearing aid fitting, and payment processing.

UnitedHealthcare Hearing offers custom programmed technology with features such as:

- Rechargeable batteries.
- Wireless connectivity.
- Water resistance.
- One-year supply of free batteries on Basic and Advanced technology levels or a five-year supply of free batteries on Premium technology level.
- 70-day trial for Direct Delivery Devices or 45-day trial for hearing aids dispensed by a UnitedHealthcare Hearing Provider.
- A three-year warranty that covers repair, and one-time loss or damage replacement.

Through UnitedHealthcare Hearing, you will receive a $3,000 Benefit maximum every three years after paying the applicable copayment for hearing aids. You will be responsible for all hearing aid costs that exceed the Benefit maximum.

There are two convenient hearing care options for choice and flexibility. Seek care through: Right2You virtual care or in-person with a UnitedHealthcare provider. Coverage includes routine hearing test, hearing aid evaluations and consultation, and follow-up care.

To find out additional information, visit www.uhchearing.com or call 866-334-4425.

## Attachment V – Level2

Small changes make big results for people with Type 2 diabetes. Level2™ is a program offering personalized and data-driven care for individuals, enrolled in the Bind Plan, with Type 2 diabetes.

Through an individualized approach, guided by wearable technologies and personal coaching, Level2 focuses on the reduction of A1C, increasing time in range of blood glucose levels, and the possibility of Type 2 diabetes remission.

**Level2 Details**

The Level2 experience includes a small Continuous Glucose Monitoring (CGM) device that is applied to your stomach. It's easy to use and wirelessly tracks your blood sugar in real-time, directly to an app on your smartphone. When you enroll in Level2, we'll also give you a Fitbit® activity tracker to help you track daily activity.

Using data from both your CGM and your Fitbit®, our experts will provide you with personalized insights. Your team of experts includes registered dietitians, social workers, registered nurses, medical doctors and endocrinologists.

You can talk to or message your personal Level2 care team when it works for you. They'll be with you every step of the way as you work toward putting your Type 2 diabetes in remission by targeting personalized food, activity and medicine interventions.

**Who's Eligible**

Employees and eligible spouses or domestic partners who are enrolled in the Bind Plan and have a diagnosis of Type 2 diabetes.

**Enhanced Drug Benefit:**

Members enrolled in Level2 can earn an enhanced drug benefit by engaging with the program each quarter. The enhanced drug benefit provides certain diabetic medications and supplies and no cost share to the member. In order to earn the enhanced drug benefit, members need to meet the adherence criteria as established by Level2. Once that criteria is met, you earn the benefit for the next calendar quarter.

**How To Learn More and Enroll:**

To learn more about Level2, go to www.LVL2.com.

## Attachment VI – Medical Weight Loss

Medical Weight Loss focuses on understanding the underlying conditions, medications and lifestyle behaviors that may affect weight loss efforts and offers a comprehensive evidence-based treatment plan to meet your unique needs.

### Medical Weight Loss Details

Medical Weight Loss services are offered at select locations. Employees and their spouses/domestic partners wh are enrolled in the Bind Plan are eligible to participate.

Medical Weight Loss begins by scheduling a medical assessment at an approved Medical Weight Loss location (see contact information under benefitsenroll.uhg.com and Health and Insurance>Condition Management). You provider will partner with you to identify possible contributing factors to weight gain and/or weight loss challenges (e.g., medications, certain conditions, etc.) that are many times overlooked.

The assessment and lab results are used to deliver a comprehensive, personalized care plan that may include a combination of medical, pharmaceutical (such as weight loss medication), nutrition, exercise and behavioral therapy components.

### Who's Eligible

Employees and their spouses/domestic partners who are enrolled in the Bind Plan.

### Learn More

For more details and for list of participating locations, go to benefitsenroll.uhg.com

## Attachment VII – Rewards for Health

With Rewards for Health, you receive comprehensive, personalized health recommendations based on data from your health survey, biometrics and other health information. Your recommended actions will expand over time as Rewards for Health receives additional data. You'll receive more rewards for actions that are proven to have better outcomes for your health. Participation in Rewards for Health is voluntary. However, to earn rewards, you will have to participate in the program activities. You can earn up to $600 (or $1,200 when your enrolled spouse or domestic partner participates) by completing recommended health actions.

### How to Earn Rewards

In order to earn rewards, take the following steps:

1. Take the health survey and earn $25.
2. Complete a biometric screening and earn $75. There are several ways to complete your biometric screening. Please visit www.benefitsenroll.uhg.com for more information.
3. Complete your recommended actions and earn up to $600.

*Important Notes:*

- The health survey and biometric screening may be required before you receive your personalized recommendations with reward amounts.
- You are not required to complete a biometric screening if you:
    1. Completed a biometric screening between July 1, 2020, and Dec. 31, 2020. A screening completed during this time will be applied to the 2021 incentive period and is eligible for the $75 reward. If the reward is not visible in your 2021 Rewards Account, you may need to submit a Physician Results form to be awarded credit in 2021. You may download a Physician Results Form by visiting Rally>Biometric Screening or call Rally Customer Support at 844-334-4944 for more information.
    2. Are pregnant.
    3. Are enrolled in Medical Weight Loss. Earn the full reward by taking the health survey ($25) and enrolling and/or continuing to engage with your care team.

### How to Spend your Rewards

You choose how to spend your rewards as follows:

- Medical Premium Discounts: The reward will be spread out and applied to your paycheck on a per pay-period basis during 2021 after you earn rewards.
- Stride Marketplace: Items in the Stride Marketplace are continuously being expanded and include items such as gift cards for vacations and fitness devices. Visit the site periodically to see what has been added. Be aware that items in the Stride Marketplace are considered taxable upon redemption. Tax withholdings will be applied to your paycheck as soon as administratively feasible.

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Rewards can be earned and redeemed between January 1 – November 30. If there is a balance in your Rewards Account after November 30, any remaining dollars will automatically be applied to your 2021 medical plan premium discount. To the extent the balance in your Rewards Account exceeds any remaining 2021 medical plan premiums, such excess dollars will be paid as cash in 2021.

You must be employed and enrolled in an eligible medical plan at the time of reward funding. Upon termination of your employment or disenrollment from an eligible medical plan, all rewards that have not yet been redeemed are forfeited. This includes dollars in the Stride Marketplace and medical plan premium discounts that have not yet been applied.

Rewards for participating in a well-being program are available to all eligible members. If you think you may be unable to complete an action, you may qualify for an opportunity to earn the same reward by a different means. Contact Rally Customer Support at 844-334-4944 to find a well-being program that will meet your needs and we will work with you (and, if you wish, with your provider).

**Other Wellness Rewards**

The company may offer other wellness programs from time to time. For any such program, the company will determine, in its sole discretion, the amount of any wellness reward offered in connection with the program, the class of eligible employees, the wellness action required to earn any reward and the methods of reward payment. If you are eligible for an additional wellness program, the company will notify you of the program's terms and conditions.