UnitedHealthcare®
Oxford

JANUARY 1, 2023

SPD SUPPLEMENT

Oxford Health Plan
Motion Picture Industry Health Plan

LI1001 (132862)

MPI
MOTION PICTURE INDUSTRY
PENSION & HEALTH PLANS™

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SECTION 1

Introduction

The Motion Picture Industry Health Plan ("Plan") is pleased to provide you with this Supplemental Summary Plan Description (SPD), which describes the health Benefits available to you and your Covered family members under the Plan. It includes summaries of:

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

This document is intended to supplement the Summary Plan Descriptions for the Motion Picture Industry Health Plan for Active Participants and for Retired Participants ("SPD").

Oxford is a private healthcare claims administrator and helps your Plan to administer claims. Although Oxford will assist you in many ways, it does not guarantee any Benefits. The Motion Picture Industry Health Plan is solely responsible for paying Benefits described in the Supplemental SPD.

Please read the Supplemental SPD thoroughly to learn how Oxford works. If you have questions, contact the Plan or call the number on the back of your ID card.

HOW TO USE THE SUPPLEMENTAL SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of the Supplemental SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments by requesting printed copies by contacting the Plan.
- Capitalized words in the Supplemental SPD have special meanings and are defined by Sections or in the *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in the *Glossary*.
- The Directors of the Motion Picture Industry Health Plan are the Plan Sponsor and Plan Administrator.
- If there is a conflict between the Supplemental SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, the Supplemental SPD will control.

SECTION 2

Telephone and Address Reference Guide

Oxford wants you to be able to contact Oxford how, when and where you want to.

Oxford's website www.oxhp.com is available 24 hours a day, seven days a week to obtain answers to your questions. If you need to reach Oxford by mail or telephone, it's important for you to know how. The following is a list intended to make your interactions with Oxford a little bit easier!

1ST LEVEL STANDARD GENERAL ADMIN AND CLINICAL APPEALS

Submit claim forms to this address

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

1-800-444-6222 and
1-800 201-4911 (After 5:00 p.m)

2ND LEVEL STANDARD GENERAL ADMIN AND CLINICAL APPEALS

Motion Picture Industry Health Plan
Attn Benefits/Appeals Committee
P.O. Box 1999
Studio City, CA 91614

MEDICAL EMERGENCIES AND URGENT CARE

Medical Management Coordinator
1-800-444-6222 and
1-800 201-4911 (After 5:00 p.m)

OXFORD CUSTOMER SERVICE

Customer Service Representatives are available Monday- Friday 8:00 a.m. to 6:00 p.m.
1-800-444-6222 or the number on the back of your ID card

PREAUTHORIZATION

1-800-444-6222

BEHAVIORAL HEALTH

1-800-201-6991

SECTION 3

How The Plan Works

GETTING STARTED

This document contains a detailed description of your Plan. You should be familiar with all of the Plan's terms and conditions. They determine what coverage you have and what amounts the Plan will pay.

- This Plan provides access to Covered Services from Providers within Oxford's Freedom In-Network, which is Oxford's largest network. Under the Plan, you can choose to receive Covered Services "In-Network" from Oxford's Freedom In-Network Providers or you can receive Covered Services "Out-of-Network" from Freedom Out-of-Network Providers.
- Your Out-of-Pocket responsibility differs depending upon whether Covered Services are obtained through your In-Network or Out-of-Network Benefits. Generally, you will be responsible for paying a higher portion of your medical expenses when you obtain Out-of-Network Benefits. Please refer to the *Oxford Highlights* for specific Out-of-Pocket expenses.

COST-SHARING EXPENSES AND ALLOWABLE AMOUNTS

Your share of the costs will depend on the following:

❶ Annual Deductible

The Annual Deductible is the total of the Allowable Amount, or the Recognized Amount when applicable, you must pay each calendar year for Out-of-Network Covered Services before you are eligible to begin receiving Benefits.

The amounts you pay toward your Annual Out-of-Network Deductible accumulate over the course of the calendar year. If you have both an In-Network Annual Deductible and an Out-of-Network Annual Deductible, the Cost-Sharing for Out-of-network services does not apply towards your In-Network Deductible. Any charges of an Out-of-Network Provider that are in excess of the Allowable Amounts do not apply towards the Annual Deductible.

Except where stated otherwise, you must pay the amount in the Schedule of Benefits section of the Supplemental SPD for Covered Services before the Plan provides coverage.

The Deductible runs from January 1 to December 31 of each calendar year.

❷ Co-payment

A Co-Payment is the amount you pay each time you receive certain Covered Services. The Co-payment is a flat dollar amount and is paid at the time of service or when billed by the provider. Co-payment do not count toward the Out-of-Pocket Maximum. Co-payments do not count toward the Annual Deductible. If the Allowable Amount is less than the Co-payment, you are only responsible for paying the Allowable Amount and not the Co-payment.

❸ Coinsurance

Coinsurance is the percentage of Allowable Amount, or the Recognized Amount when applicable, that you are responsible for paying for Out-of-Network Covered Services. Coinsurance is a fixed percentage that applies to certain Covered Services after you meet the Annual Deductible.

Coinsurance – Example

Let's assume that you receive Plan Benefits for outpatient surgery from an Out-of-Network Provider. Since the Plan pays 70% after you meet the Annual Deductible, you are responsible for paying the other 30%. This 30% is your Coinsurance.

❹ Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Services. If your eligible Out-of-Pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Allowable Amount for Covered Services through the end of the calendar year.

Out-of-Network Out-of-Pocket Maximum

The Supplemental SPD has a separate Out-of-Out-of-Pocket Maximum in the Schedule of Benefits, in Section 4, *Oxford Highlights* of the Supplemental SPD for Out-of-Network benefits. When you have met your Out-of-Network Out-of-Pocket Maximum in payment of Out-of-Network Deductibles, Co-Payments, and Coinsurance for a Plan Year, shown in the *Oxford Highlights* section of the Supplemental SPD, Oxford will provide coverage for 100% of the Allowable Amount for Covered Out-of-Network Services as described in the Schedule of Benefits section of the Supplemental SPD.

Any charges of an Out-of-Network Provider that are in excess of the Allowable Amount, or the Recognized Amount when applicable, do not apply towards your Out-of-Pocket Maximum. Cost-Sharing for In-Network services does not apply toward Your Out-of-Network Out-of-Pocket Maximum. The Preauthorization penalty described in the *How Your Coverage Works* section of this Supplemental SPD does not apply toward Your Out-of-Network Out-of-Pocket Maximum. The Out-Network Out-of-Pocket Maximum runs from January 1 to December 31 of each calendar year.

Your Additional Payments for Out-of-Network Benefits

When you receive Covered Services from a Out-of-Network Provider, in addition to the applicable Co-Payments, Coinsurance, and Deductible, shown in the *Oxford Highlights* section of this Supplemental SPD, you must also pay the amount, if any, by which the Out-of-Network Provider's actual charge exceeds the Allowable Amount. This means that the total of the Plans coverage and any amounts you pay under your applicable Deductible, Co-Payment, and Coinsurance may be less than the Out-of-Network Provider's actual charge.

When you receive Covered Services from an Out-of-Network Provider, the Plan will apply nationally-recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis code for the services you received. Sometimes, applying these rules will change the way that the Plan pays for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently.

As an example, your Provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. Oxford will make one inclusive payment in that case, rather than a separate payment for each billed code. Another example of when Oxford will apply the payment rules to a claim is when you have surgery that involves two surgeons acting as "co-surgeons." Under the payment rules, the claim from each Provider should have a "modifier" on it that identifies it as coming from a co-surgeon. If Oxford receives a claim that does not have the correct modifier, Oxford will change it and make the appropriate payment.

❺ Allowable Amounts

Allowable Amounts are the amount the Claims Administrator determines that the Plan will pay for Benefits.

- For In-Network Benefits for Covered Health Care Services provided by an In-Network provider, except for your cost sharing obligations, you are not responsible for any difference between Allowable Amounts and the amount the provider bills.
- For Out-of-Network Benefits, except as described below, you are responsible for paying, directly to the Out-of-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Allowable Amounts.
  - For Covered Health Care Services that are Ancillary Services received at certain In-Network facilities on a non-Emergency basis from Out-of-Network Physicians, you are not responsible, and the Out-of-Network provider may not bill you, for amounts in excess of your Co-Payment, Coinsurance or deductible which is based on the Recognized Amount as defined in the Supplemental SPD.
  - For Covered Health Care Services that are non-Ancillary Services received at certain In-Network facilities on a non-Emergency basis from Out-of-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below, you are not responsible, and the Out-of-Network provider may not bill you, for amounts in excess of your Co-Payment, Coinsurance or deductible which is based on the Recognized Amount as defined in the Supplemental SPD.
  - For Covered Health Care Services that are Emergency Health Care Services provided by an Out-of-Network provider, you are not responsible, and the Out-of-Network provider may not bill you, for amounts in excess of your applicable Co-Payment, Coinsurance or deductible which is based on the Recognized Amount as defined in the Supplemental SPD.
  - For Covered Health Care Services that are Air Ambulance services provided by an Out-of-Network provider, you are not responsible, and the Out-

of-Network provider may not bill you, for amounts in excess of your applicable Co-Payment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by an In-Network provider which is based on the Recognized Amount as defined in the Supplemental SPD.

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

Network Benefits

Allowable Amounts are based on the following:

- when Covered Health Care Services are received from an In-Network provider, Allowable Amounts are the Claims Administrator's contracted fee(s) with that provider.
- when Covered Health Care Services are received from an Out-of-Network provider as arranged by the Claims Administrator, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Care Services, Allowable Amounts are negotiated by the Claims Administrator or an amount permitted by law.

Out-of-Network Benefits

When Covered Health Care Services are received from an Out-of-Network provider as described below, Allowable Amounts are determined as follows:

For non-Emergency Covered Health Care Services received at certain In-Network facilities from Out-of-Network Physicians when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act with respect to a visit as defined by the Secretary, the Allowable Amount is based on one of the following in the order listed below as applicable:

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

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

Important Notice

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

For Emergency Health Care Services provided by an Out-of-Network provider, the Allowable Amount is based on one of the following in the order listed below as applicable:

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

Important Notice

You are not responsible, and an Out-of-Network provider may not bill you, for amounts in excess of your applicable Co-Payment, Coinsurance or deductible which is based on the Recognized Amount as defined in the Supplemental SPD.

For Air Ambulance transportation provided by an Out-of-Network provider, the Allowable Amount is based on one of the following in the order listed below as applicable:

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

Important Notice

You are not responsible, and an

Out-of-Network provider may not bill you, for amounts in excess of your Co-Payment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by an In-Network provider which is based on the Recognized Amount as defined in the Supplemental SPD.

For Emergency ground ambulance transportation provided by an out-of-Network provider, the Allowed Amount, which includes mileage, is a rate agreed upon by the out-of-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

Important Notice

Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here.

When Covered Health Care Services are received from an Out-of-Network provider, except as described above, Allowable Amounts are determined, based on one of the following:

- negotiated rates agreed to by the Out-of-Network provider and either the Claims Administrator or one of the Claims Administrator's vendors, affiliates or subcontractors.
- for Covered Health Care Services other than Pharmaceutical Products, Allowable Amounts are determined based on the 70th percentile of an available data resource of competitive fees in that geographic area.
- when Covered Health Care Services are Pharmaceutical Products, Allowable Amounts are the average wholesale price of such Pharmaceutical Products as set forth in the Red Book drug pricing resource. The Pharmaceutical Product pricing information is updated annually.
- when Red Book does not have a price for the product, an alternative pricing source such as RJ Health or an internally developed pharmaceutical pricing resource to determine the average wholesale price for the covered Pharmaceutical Product will be used.
- when a rate is not available for the service, the Allowed Amount is based on 20% of the billed charge.

Don't Forget Your ID Card

Remember to show your Oxford ID card every time you receive health care services from a Provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

HOW YOUR COVERAGE WORKS

❶ Network Services

You may seek primary preventative or specialty care from any In-Network Provider with a referral. You and your eligible Dependents are still required to select a Primary Care Physician (PCP). If you select a PCP when you enroll, Oxford encourages you to use your PCP when you need primary or preventive Care. Oxford encourages you to allow your PCP to coordinate your specialty care needs. In this manner, continuity of care can be maintained.

To receive the highest level of benefits, contact an In-Network Physician when you need medical assistance. In most instances, he or she will be able to provide the care you need. If you require services from another provider, be sure that he or she is also an In-Network Provider by checking the roster of In-Network Providers, or by calling Oxford.

Except for Emergencies, and Preauthorized visits to Out-of-Network Providers, only services provided by an In-Network Provider are Covered on an In-Network basis.

If an In-Network Provider recommends Hospital or surgical services, they will need an authorization from Oxford before you obtain those services. This process is referred to as Preauthorization. Before entering the Hospital, you may want to check with Customer Service to verify that the Hospital is an In-Network Provider and that the services have been Preauthorized.

Looking for an In-Network Provider?

In addition to other helpful information, www.oxhp.com, the Claims Administrator's consumer website, contains a directory of health care professionals and facilities in the Claims Administrator's In-Network. While In-Network status may change from time to time, www.oxhp.com has the most current source of In-Network information. Use www.oxhp.com to search for Providers available in your Plan.

❷ Out-of-Network Services

If you decide you do not want to use an In-Network Provider, the Plan still provides coverage for a broad range of medical services. However, Covered Services not obtained from In-

Network Providers will be subject to Deductible, Coinsurance and the amount, if any, by which the Out-of-Network Provider's actual charge exceeds the Allowable Amounts. This means that the total of the Plan coverage and any amounts you pay under your applicable Deductible, Co-Payment, and Coinsurance may be less than the Out-of-Network Provider's actual charge. Further, Out-of-Network Providers may not be familiar with Oxford's Plan. Therefore, you should review the "Covered Services" and "Limitations and Exclusions" sections of the Supplemental SPD. You may also contact Customer Service if you have any questions concerning Covered Services under this Plan. In any case where benefits are limited to a certain number of days or visits, such limits apply in the aggregate to In-Network and Out-of-Network services.

Surgical procedures and Hospitalizations still require Preauthorization. You are responsible for obtaining any required Preauthorization. You must call (or have your Physician call) Oxford's Customer Service to obtain the Preauthorization. Failure to Preauthorize will result in a 50% reduction in benefits.

In-Network Exceptions

If an In-Network Provider cannot perform or deliver the Covered Services you need, you may receive In-Network coverage for Medically Necessary Covered Services from an Out-of-Network Provider. First, you must contact Oxford and Preauthorize the use of an Out-of-Network Provider. Before Preauthorizing the use of an Out-of-Network Provider for In-Network Covered Services, Oxford may recommend another In-Network Provider who is able to render the services you need. However, if Oxford agrees that it is necessary for you to use an Out-of-Network Provider (and Preauthorize the services), there will be no additional cost to you beyond your required Co-Payment.

Additionally, Preauthorization requests for admissions to Out-of-Network facilities (e.g., hospitals, rehabilitation centers) to be Covered on an In-Network basis will not be approved unless Oxford agrees that an In-Network facility is unable to meet your specific medical needs. While you and your In-Network Provider may discuss having a procedure performed at a specific Out-of- Network facility, In-Network coverage is only available if Oxford agrees that the procedure cannot be safely performed at any In-Network facility. Any non-emergency Covered Services received at an Out-of-Network facility will be subject to the Out-of-Network level of benefits.

❸ Preauthorization

Some Covered Health Care Services require Preauthorization. Physicians and other health care professionals who participate in an In-Network are responsible for obtaining Preauthorization. However, if you choose to receive Covered Health Care Services from an Out-of-Network provider, you are responsible for obtaining Preauthorization before you receive the services.

Preauthorization Procedure

If you seek coverage for Out-of- Network services that require Preauthorization you must call Oxford at the number indicated on your ID card. After receiving a request for approval, Oxford will review the reasons for your planned treatment and determine if benefits are available. Criteria will be based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.

Medical Management

The benefits available to you under this Supplemental SPD are subject to pre-service, concurrent and retrospective reviews to determine when services should be Covered by your Plan. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be provided.

❹ Medical Necessity

The Plan covers benefits described in this Supplemental SPD as long as the health care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, "service") is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that the Plan has to cover it.

Oxford may base its decision on a review of:

- your medical records;
- Oxford medical policies and clinical guidelines;
- medical opinions of a professional society, peer review committee or other groups of Physicians;
- reports in peer-reviewed medical literature;

- reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- the opinion of Health Care Professionals in the generally-recognized health specialty involved;
- the opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- they are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for your illness, injury, or disease;
- they are required for the direct care and treatment or management of that condition;
- your condition would be adversely affected if the services were not provided;
- they are provided in accordance with generally-accepted standards of medical practice;
- they are not primarily for the convenience of you, your family, or your Provider;
- they are not more costly than an alternative service or sequence of services, that is they are at least as likely to produce equivalent therapeutic or diagnostic results. When setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, the Plan will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the drug could be provided in a Physician's office or the home setting.

See the section on *Claims Procedures* in the Supplemental SPD for your right to an internal appeal of Oxford's determination that a service is not Medically Necessary.

❺ Second Opinions

Oxford reserves the right to require a second opinion for any surgical procedure. At the time of Preauthorization, you may be advised that a second opinion will be required in order for the services to be Covered. If a second opinion is required, Oxford will refer you to an In-Network Provider for a second opinion.

In the event that the first and second opinions differ, a third opinion will be required. Oxford will designate a new In-Network Provider. The third opinion will determine whether or not the surgery is Preauthorized. There will be no cost to you for the second or third opinion. You may also request a second opinion.

❻ Emergencies

If you have an Emergency, you should obtain medical assistance immediately or call 911. Emergency room care is not subject to Oxford's prior approval. **However, only Emergencies, as defined in this Supplemental SPD, are Covered in an Emergency room**. Therefore, before you seek treatment, you may want to be certain that this is the most appropriate place to receive care. You can call Oxford's medical management coordinators. They are available 24 hours a day, 7 days a week. The coordinator will direct you to the emergency room of a Hospital or other appropriate facility.

❼ Urgent Care

For In-Network coverage, you must call Oxford's medical management coordinators and follow the instructions you will be given. When this procedure is followed, your Urgent Care will be Covered in full, less any required Co-Payment. This coverage will be provided regardless of where you are (in or out of the Service Area) when the need for Covered Services occurs. **If you do not call first, coverage will only be available on an Out-of-Network basis.**

❽ Diagnostic Testing and Laboratory Services

If your In-Network Provider recommends laboratory testing, remind him or her to use an In-Network Provider. In addition, Covered x-rays or diagnostic procedures performed at In-Network facilities will be Covered by the Plan without any required Co-Payment. Unless you are hospitalized, Hospitals are not In-Network Providers for these tests.

❾ Customer Service

All coverage is subject to the terms and conditions contained in your Plan documents. You should understand your rights and obligations before you obtain services. If you have questions, customer service will be pleased to help you.

⑩ Standing Referrals

Participants who need ongoing Specialty Care may receive a "standing referral" to an In-Network Specialist. Oxford's Medical Director will consult with your PCP and In-Network Specialist to determine if such a referral is appropriate. The referral will be provided pursuant to a treatment plan that has been approved by Oxford's Medical Direct.

Note

The treatment plan may limit the amount of visits or the period of time during which the visits must occur. Further, the treatment plan may require the In-Network Specialist to provide your PCP with regular updates on the care being provided. You, your PCP or your In-Network Specialist may call Medical Management and request a standing referral.

Additionally, Participants who have a life-threatening condition or disease and Participants who have a degenerative and disabling condition or disease may request a standing referral to an In-Network Specialty Care Center. This referral is available only if the condition or the disease requires specialized medical care over a prolonged period of time. Further, the center must have the necessary medical expertise and be properly accredited or designated (as required by state or federal law or a voluntary national health organization) to provide the Medically Necessary care required for the treatment of the condition or disease. The services to be provided will be Covered only to the extent they are otherwise Covered under this SPD.

⑪ More Information

As a Participant, you automatically receive a SPD.

Note

You can request additional information about Oxford and your coverage under this SPD.

SELECTING A PRIMARY CARE PHYSICIAN

❶ Selecting Your PCP

As described, you were required to select a PCP when you enroll. Please refer to the roster of In-Network Providers when selecting a PCP.

❷ Primary Provider of OB/GYN Care

In addition to a PCP, female Participants should select an In-Network Provider of OB/GYN Care.

❸ Network Specialists as PCPs

Participants who have a life-threatening condition or disease and Participant who have a degenerative and disabling condition or disease may request to elect an In-Network Specialist as their PCP. The designated In-Network Specialist will become responsible for providing and coordinating all of the Participant's Primary Care and Specialty Care. He or she will be able to order tests, arrange procedures and provide referrals and medical services in the same capacity as a PCP.

This election is available only if the condition or disease requires specialized medical care over a prolonged period of time. The desired In-Network Specialist must have the necessary qualifications and expertise to treat the Participant's condition or disease. A Participant may request this election at the time of enrollment or upon diagnosis.

❹ Changing Your PCP

If you selected a PCP when you enrolled, you may change your PCP (or Provider of OB/GYN Care) at any time. Select a new Provider from the roster of In-Network Physicians then call Customer Service to update your selection. The change will become effectively immediately.

PROVIDER PARTICIPATION AND TRANSITIONAL CARE

❶ Provider Participation

Oxford cannot promise that a specific Provider, even though listed in the roster of participating physicians, will be available. An In-Network Provider may end his or her contract with Oxford, or decide not to accept additional patients. If you have any questions about whether or not a particular Provider is currently participating or accepting new patients, please feel free to call Customer Service and inquire. If your PCP or In-Network Specialist leaves Oxford's In-Network, you should work choose another PCP or In-Network Specialist in order to continue receiving care on an In-Network basis. However, if you are undergoing a course of treatment at the time your In-Network Provider leaves the In-Network, you may be eligible for Transitional Care as described below.

Before obtaining services you should always verify the In-Network status of a provider. A provider's status may change. You can verify the provider's status by calling the Claims Administrator. A directory of providers is available online at www.myuhc.com or by calling the telephone number on your ID card to request a copy. If you receive a Covered Health Care

Service from an Out-of-Network provider and were informed incorrectly prior to receipt of the Covered Health Care Service that the provider was an In-Network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for In-Network Benefits.

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

❷ Transitional Care

Your Provider Leaves the Network

If you are undergoing a course of treatment when your Provider leaves the Network, you may be able to continue to receive Covered Services for the ongoing treatment from your former Participating Provider for up to ninety (90) days from the date Your Provider's contractual obligation to provide services to You terminates. Regarding pregnancy, if the Provider leaves the Network while you are in your second or third trimester, you may be able to continue care with a former Participating Provider through delivery and any post-partum care directly related to the delivery.

In order for you to continue to receive Covered Services for up to ninety (90) days or through a pregnancy with a former Participating Provider, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of the Claims Administrator's relationship with the Provider. The Provider must also agree to provide Oxford necessary medical information related to your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, referrals, and a treatment plan approved by the Claims Administrator. If the Provider agrees to these conditions, you will receive these Covered Services as if they are being provided by a Participating Provider. You will only be responsible for any applicable In-Network cost-sharing.

Note

If the Provider was terminated by the Claims Administrator due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available..

New Participants Currently Undergoing a Course of Treatment

If you are undergoing a course of treatment with an Out-of-Network Provider at the time your coverage under this SPD becomes effective, you may be able to receive Covered Services from the Out-of-Network Provider for up to 60 days from the effective date of your coverage under the Supplemental SPD. This coverage is available only if the course of treatment is for a life-threatening disease/condition or a degenerative and disabling disease/condition. Coverage is limited to the disease/condition. Regarding pregnancy, if your coverage becomes effective while you are in your second trimester or third trimester, you may receive Covered Services from your Out-of-Network Provider through delivery and any post-partum care directly related to the delivery.

However, Transitional Care is available **only if the Provider agrees to accept as payment Oxford's negotiated fees for such service**s. Further, the Provider must agree to adhere to all of Oxford's quality assurance procedures as well as all other policies and procedures required by Oxford regarding the delivery of Covered Services. If the Provider agrees to these conditions, you will receive these Covered Services as if they are being provided by an In-Network Provider. You will only be responsible for any applicable Co-Payments.

In order to obtain Transitional Care, you or your Provider should call Medical Management at 1-800-444-6222 and request this coverage.

PATIENT/PROVIDER RELATIONSHIP

In-Network Providers are solely responsible for all health services that you receive. If you refuse to follow a recommended treatment, and the In-Network Provider believes that no professionally acceptable alternative exists, you will be so advised. In such a case, subject to the second opinion process, neither Oxford nor the In-Network Provider will have any further responsibility to provide Benefits for the condition under treatment.

PROVIDER REIMBURSEMENT

Reimbursement

The Plan reimburses our In-Network Providers in a variety of ways. The most common is a discount off the Provider's usual fee. This means the Provider agrees to accept less than what he or she would usually be paid for that service. In return, the Provider's name appears in Oxford's roster, which gives the Provider an opportunity to gain new patients from among our membership.

SECTION 4

Oxford Highlights

SUMMARY OF COVERAGE

Amounts which you are required to pay as shown below in the *Summary of Coverage* are based on Allowable Amounts or, for specific Covered Health Care Services as described in the definition of Recognized Amount in Section 13, *Glossary.*

SUMMARY OF COVERAGE		IN-NETWORK	OUT-OF-NETWORK
Financial	Single Deductible	None	$500
	Family Deductible	None	$1,000
	Coinsurance	None	30%
	Maximum Out-of-Pocket (Single)	None	$8,000
	Maximum Out-of-Pocket (Family)	None	$16,000
	Lifetime Maximum Benefit: There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.		
Preventive Care	Adult Preventive Care	No Charge	In-Network Benefit Only
	Infant and Pediatric Preventive Care	No Charge	Deductible & 30% Coinsurance
Virtual Care Services-Designated Provider		$5 Co-payment per visit	Not Covered
Outpatient Care	Primary Care Physician Office Visits	$15 Co-Payment per visit	Deductible & 30% Coinsurance
	Specialist Office Visits	$15 Co-Payment per visit	Deductible & 30% Coinsurance
	Outpatient Facility Surgery**	No Charge	Deductible & 30% Coinsurance
	Laboratory Services	No Charge at Participating Laboratories	Deductible & 30% Coinsurance
	MRIs, MRAs, PET Scan, CT Scan, Ultrasound**	No Charge	Deductible & 30% Coinsurance
	Radiology Services**	No Charge	Deductible & 30% Coinsurance
Ambulance Services	Ground and/or Air Ambulance Emergency/Non-Emergency	No Charge	No Charge (same as In-Network)
	Allowable Amounts for ground and Air Ambulance transport provided by an Out-of-Network provider will be determined as described in Section 3, *How the Plan Works.*		
Hospital Care	Physician's and Surgeon's Services**	No Charge	Deductible & 30% Coinsurance
	Semi-Private Room and Board**	No Charge	Deductible & 30% Coinsurance
	All Drugs and Medications	No Charge	Deductible & 30% Coinsurance
Emergency Care	Ambulance Service When Medically Necessary	No Charge	Deductible & 30% Coinsurance
	At Hospital Emergency Room (If member is admitted to the hospital, notification is required)	$25 Co-Payment, waived if admitted	$25 Co-Payment, waived if admitted
	If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Co-payment. The Benefits for an Inpatient Stay in a Hospital will apply instead. This does not apply to services provided to stabilize an Emergency after admission to a Hospital. Allowable Amounts for Emergency Health Services provided by an Out-of-Network provider will be determined as described under Allowable Amounts in Section 3: *How the Plan Works.*		
	Urgent Care Center	$15 Co-Payment per visit	Deductible & 30% Coinsurance
Maternity Care	Routine Prenatal and Post-Natal Care**	No Charge	Deductible & 30% Coinsurance
	Hospital Services for Mother and Child**	No Charge	Deductible & 30% Coinsurance
Skilled Nursing Facility	Unlimited Days**	No Charge	Deductible & 30% Coinsurance
Hospice Care	Inpatient Care**	No Charge	Deductible & 30% Coinsurance
	Home Hospice**	$15 Co-Payment per visit	Subject to a 20% Coinsurance

**Preauthorization upon initial visit

Preauthorization Penalty In-Network: Preauthorization is the responsibility of the Participating Provider. **Preauthorization Penalty Out-of-Network:** The Services that require Preauthorization from Out-of-Network Providers are reflected in this document. If you fail to obtain a required Preauthorization for an Out-of-Network benefit, you must pay 50% of the (Allowable Amount).

SUMMARY OF COVERAGE		NETWORK	OUT-OF-NETWORK
Home Health Care	60 Home Care Visits**	$15 Co-Payment per visit	Subject to a 20% Coinsurance
	Physician House Calls	$15 Co-Payment per visit	Deductible & 30% Coinsurance
Hemophilia Factor Benefits		$15 Co-Payment per visit	Not Covered
Substance-Related and Addictive Disorders	Inpatient Substance Use Services**	No Charge	Deductible & 30% Coinsurance
	Outpatient Substance Use Services	$15 Co-Payment per visit	Deductible & 30% Coinsurance
	Office Visits**	$15 Co-Payment per visit	Deductible & 30% Coinsurance
	Partial Hospitalization & Intensive Outpatient Program Services	$15 Co-Payment per visit	Deductible & 30% Coinsurance
Mental Health Care	Inpatient Care**	No Charge	Deductible & 30% Coinsurance
	Outpatient Care**	$15 Co-Payment per visit	Deductible & 30% Coinsurance
	Office Visits**	$15 Co-Payment per visit	Deductible & 30% Coinsurance
	Partial Hospitalization & Intensive Outpatient Program Services	$15 Co-Payment per visit	Deductible & 30% Coinsurance
Neurobiological Disorder - Autism Spectrum Disorder Services	Inpatient Care**	No Charge	Deductible & 30% Coinsurance
	Outpatient Care**	$15 Co-Payment per visit	Deductible & 30% Coinsurance
	Office Visits**	$15 Co-Payment per visit	Deductible & 30% Coinsurance
	Partial Hospitalization & Intensive Outpatient Program Services	$15 Co-Payment per visit	Deductible & 30% Coinsurance
Allergy Care	Testing, Allergy Clusters and Treatment	$15 Co-Payment per visit	Deductible & 30% Coinsurance
Chiropractic Care		$15 Co-Payment per visit	Deductible & 30% Coinsurance
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	60 Consecutive Inpatient Days per Condition/Lifetime	No Charge	Deductible & 30% Coinsurance
	90 Outpatient Visits per Condition/Lifetime	$15 Co-Payment per visit	Deductible & 30% Coinsurance
Short Term Rehabilitation	Inpatient - Unlimited** 60 Consecutive Inpatient Days per Condition/Lifetime	No Charge	Deductible & 30% Coinsurance
	Outpatient - Unlimited** 90 Outpatient Visits per Condition/Lifetime	$15 Co-Payment per visit	Deductible & 30% Coinsurance
Durable Medical Equipment (Preauthorization required for items over $500)**		No Charge when ordered by an Oxford Participating Physician	Deductible & 30% Coinsurance
Medical Supplies When Medically Necessary		Out-of-Network Benefit Only	Deductible & 30% Coinsurance
Exercise Facility	Participant	$200 Reimbursement per 6-month period	
	Spouse	$100 Reimbursement per 6-month period	
Elective Termination of Pregnancy ($350 maximum for one procedure per Member per Calendar Year)		No Charge	Deductible & 30% Coinsurance
Advanced Infertility Treatment ($10,000 per lifetime)	Specialist Office Visits**	$15 Co-Payment per visit	In-Network Benefit Only
	Inpatient Facility Services**	No Charge	In-Network Benefit Only
	Outpatient Facility Services**	No Charge	In-Network Benefit Only
Transgender	Specialist Office Visits**	$15 Co-Payment per visit	Deductible & 30% Coinsurance
	Facility Services**	No Charge	Deductible & 30% Coinsurance
Nutritional Counseling		$15 co-payment per visit	Deductible & 30% Coinsurance
Hearing Aids Limited to a single purchase of $1,500 max every 3 years per date of purchase for both ears (not for each ear) including repair/replacement.		No Charge	Deductible & 30% Coinsurance

**Preauthorization upon initial visit

Preauthorization Penalty In-Network: Preauthorization is the responsibility of the Participating Provider. **Preauthorization Penalty Out-of-Network:** The Services that require Preauthorization from Out-of-Network Providers are reflected in this document. If you fail to obtain a required Preauthorization for an Out-of-Network benefit, you must pay 50% of the (Allowable Amount).

SECTION 5

Covered Services

WHAT THIS SECTION INCLUDES:

- Covered Services for which the Plan pays Benefits.

You will receive Covered Services in accordance with the terms and conditions of the Supplemental SPD only when the Covered Service is:

- Medically Necessary;
- properly Preauthorized, when required;
- received while your coverage is in force;
- not excluded under the Supplemental SPD; and
- not in excess of the benefit limitations described in the Supplemental SPD.

Benefits are provided for services delivered via Telehealth/ Telemedicine. Benefits are also provided for Remote Physiologic Monitoring. For the Covered Services delivered via Telehealth/ Telemedicine, your Benefits are the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified.

All Covered Services are subject to the Co-Payments, Coinsurance and Deductibles specified under the *Oxford Highlights*. All reimbursement for services rendered by Out-of-Network Providers is subject to Out-of-Network Reimbursement Amounts.

Except for Emergencies, Preauthorized Urgent Care, or when Oxford Precertifies the use of an Out-of-Network Provider **any Covered Service you obtain from an Out-of-Network Provider will be Covered on an Out-of-Network basis.**

Important

Oxford reserves the right to provide benefits in the manner it determines to be the most cost effective. Based on Oxford's medical policies, Oxford reserves the right to provide benefits in the manner, and to the extent, Oxford believes is Medically Necessary.

A PRIMARY AND PREVENTATIVE CARE

Primary Care consists of office visits, house calls, and Hospital visits provided by your Provider for consultations, diagnosis and treatment of medical conditions, injury and disease that do not require the services of a specialist.

Preventive Care consists of the following services, performed by your Provider for the purpose of promoting good health and early detection of disease.

1 PREVENTIVE CARE

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

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force;*
- immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;*
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration (HRSA);*
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *HRSA*; and
- with respect to women, Preventive care Benefits defined under the *HRSA* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. Benefits are only available if breast pumps are obtained from a DME Provider or Physician.

2 VIRTUAL CARE SERVICES THROUGH DESIGNATED PROVIDER

Virtual visits for Covered Health Care Services that include the diagnosis and treatment of less serious medical conditions through

live audio with video technology or audio only. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health specialist, through use of live audio with video technology or audio only outside of a medical facility (for example, from home or from work).

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

Note

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

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

Virtual visits with providers who can also make an appointment to be seen in their office such as your regular primary care physician or a psychologist are consider Physician Office visits.

③ DIABETIC EQUIPMENT, SUPPLIES AND EDUCATION

Diabetic Supplies, Education and Self-Management are Covered as follows:

Supplies

The following equipment and related supplies will be Covered for insulin dependent and non-insulin dependent Participants when Medically Necessary as determined by the Participant's Physician:

- Acetone Reagent Strips
- Acetone Reagent Tablets
- Alcohol Wipes
- All insulin preparations
- Automatic Blood Lance Kit
- Blood Glucose Kit
- Blood Glucose Strips (Test or Reagent)
- Blood Glucose Monitor with or without special features for visually impaired, control solutions, and strips for home blood glucose monitor (models with special features for the visually impaired must be Preauthorized by Oxford's Medical Director)
- Cartridges for the visually impaired Diabetes data management systems
- Disposable insulin and pen cartridges
- Drawing-up devices for the visually impaired
- Equipment for use of the Pump
- Glucose Acetone Reagent Strips
- Glucose Reagent Strips
- Glucose Reagent Tape
- Injection Aides
- Injector (Busher) Automatic
- Insulin Cartridge Delivery
- Insulin Infusion Devices (Preauthorization is required for this item)
- Insulin Pump
- Lancets
- Oral agents such as glucose tablets or gels
- Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones

Additional items may also be Covered if the Participant's Physician determines they are Medically Necessary and prescribes them for the Participant. Such additional items must be Preauthorized by one of Oxford's Medical Directors and be in accordance with the treatment plan developed by the Physician for the Participant.

Self-Management and Education

Education on self-management and treatment of diabetes is Covered:

- upon the initial diagnosis;
- if there is a significant change in the Participant's condition; or
- the Physician decides that a refresher course is necessary.

It must be provided:

- in a Physician's office either by the Physician or his/her qualified nurse during an office visit or in a group setting.
- upon a Physician's referral to the following non-Physician, medical educators (qualified health providers): certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians.
- whenever possible, in a group setting, regardless of whether the Provider is a Physician or a qualified health provider. Education will also be provided in the Participant's home if the Participant is homebound.

④ HEALTH EDUCATION

Health Education, information and health care literature which is made available to Participant's through various programs provided and developed by Oxford. These programs and information are provided without cost to Participants. Such programs include Oxford's Healthy Mother,

Healthy Baby Program; Oxford's Better Breathing Program and Oxford's Healthy Mind, Healthy Body magazine.

⑤ NUTRITIONAL COUNSELING

The Plan will pay for Covered Health Care Services for Nutritional Counseling services provided by an appropriate licensed healthcare professional when:

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

Some examples of such medical conditions include, but are not limited to:

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

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

Ⓑ SPECIALTY CARE

Specialty Care consists of medical care and services, including office visits, house calls, hospital visits and consultations for the diagnosis and treatment of disease or injury as described below.

Note

Most Specialty Care services require Preauthorization.

① SURGICAL AND OBSTETRICAL SERVICES

Physicians' services for surgical and obstetrical procedures on an inpatient and outpatient basis, including the services of the surgeon or specialist, assistant, and anesthetist or anesthesiologist together with preoperative and postoperative care. Deliveries and related services that are performed by a certified nurse midwife are also Covered.

Hospital admissions, including maternity admissions, require Preauthorization. When possible, the Preauthorization should be obtained at least 14 days in advance of the service.

② MATERNITY AND NEWBORN CARE*

Maternity Care

Services and supplies for maternity care provided by a Physician, licensed nurse midwife, Hospital or birthing center will be Covered for prenatal care (including one visit for genetic testing), postnatal care, delivery and complications of pregnancy. The Plan provides a minimum inpatient stay of 48 hours following a vaginal delivery and 96 hours following a cesarean delivery for both the mother and the newly born child or children. While in the hospital, maternity care also includes, at a minimum, parent education, assistance and training in breast or bottle-feeding and the performance of any necessary maternal and newborn clinical assessments. Unless the admission to the Hospital or birthing center is made on an Emergency basis, the admission must be Preauthorized.

The mother has the option to leave the hospital sooner than described above. If she decides to be discharged early, she will be provided with one home visit. The home visit must be requested by the mother within 48 hours of a vaginal birth or within 96 hours of a cesarean birth. The visit will occur within 24 hours of the later of: the mother's request; or her discharge from the hospital. This visit is not subject to deductible or Co-Payment. Additionally, the visit will not be deducted from the Home Health Care visits Covered under the Supplemental SPD.

The home visit consists of a visit by a professional RN to provide the following post-delivery care: an assessment of the mother and child, instruction on breastfeeding, cleaning and care for child; and any required blood tests ordered by either the mother's or the child's Physician.

In-Network coverage for a routine delivery or maternity care outside of the service area is limited. Oxford defines a "routine delivery" as a full-term delivery that has occurred without any complications. If you arrange to give birth at a facility outside of the service area, and the delivery is routine, the Service will be Covered as an Out-of-Network benefit and will be subject to Deductible and Coinsurance. Oxford will assume that you have arranged to give birth at a facility outside of the service area if you travel to the area of the facility near the time of your delivery. In those instances where the Out-of-Network facility is near the service area, routine deliveries will be Covered as an Out-of-

*Preauthorization required for certain services

Network benefit if you could safely have delivered in an In-Network facility. Exceptions will be made on a "case" by "case" basis if Oxford determines that circumstances beyond your control (such as a death in your family) required you to be outside of the service area at the time of your delivery.

Interruption of Pregnancy

Therapeutic abortions are Covered. Non-therapeutic abortions in cases of rape, incest or fetal malformation are also Covered. The Plan covers elective abortions for one procedure per Participant, per Calendar year.

Newborn Care*

Care for newborns includes preventive health care services (including electrophysiologic screening measures and periodic monitoring of infants for delayed onset of hearing loss), routine nursery care, and treatment of disease and injury. Treatment of disease and injury includes treatment of prematurity and medically diagnosed congenital defects and birth abnormalities which cause anatomical functional impairment. The Plan also covers, within the limits of the Supplemental SPD, necessary transportation costs from the place of birth to the nearest specialized treatment center.

Network and Out-of-Network, routine nursery and preventive Newborn Care does not require Preauthorization. Circumcision performed by a licensed medical practitioner during the delivery inpatient stay does not require Preauthorization. However, services that generally require Preauthorization (such as surgery) must be Preauthorized.*

③ TREATMENT OF INFERTILITY

Basic Infertility Services

Basic Infertility Services will be provided to a Participant who, in Oxford's opinion, is an appropriate candidate for infertility treatment. Basic Infertility Services consist of: initial evaluation, semen analysis, laboratory evaluation, evaluation of ovulatory function, postcoital test, hysterosalpingogram and medically appropriate treatment of ovulatory dysfunction with Clomiphene Citrate.

Comprehensive Infertility Services

If the Basic Services do not result in increased fertility, Medical Management may Preauthorize Comprehensive Infertility Services. These services include: ovulation induction and monitoring with ultrasound; artificial insemination; hysteroscopy; laparoscopy; and laparotomy.

Advanced Infertility Services

Should the Comprehensive Infertility Services fail to increase fertility, Oxford's Medical Director may Preauthorize the following Advanced Infertility Services: in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT).

④ ALLERGY TESTING AND TREATMENT

The Plan covers testing, allergy clusters and evaluations, including injections, and scratch and prick tests to determine the existence of an allergy. The Plan covers allergy treatment, including desensitization treatments, routine allergy injections and serums.

⑤ HABILITATION SERVICES

The Plan covers Habilitation Services consisting of physical therapy, speech therapy, and occupational therapy, in the outpatient department of a Facility or in a health care professional's office. Refer to your Schedule of Benefits to determine if a limit applies to your plan.

⑥ REHABILITATION SERVICES

Rehabilitation therapy including physical therapy, speech therapy, and occupational therapy, is Covered on an outpatient or inpatient basis. Coverage on an outpatient basis is limited to the amount of visits shown in the *Oxford Highlights*. For the purposes of this benefit (both inpatient and outpatient), "per condition" means the disease or injury causing the need for the therapy. For Covered Services received under this benefit you are eligible to receive up to the specified amount for the singular condition as noted in the *Oxford Highlights*. The accumulation of this limit is based on the "condition" and not the therapy type. Unrelated conditions are subject to separate maximums. A "session" is a period of time, up to 45 minutes, in which therapy is performed.

Speech or occupational therapy is Covered only when it is related to the treatment or diagnosis of Your physical illness or injury (in the case of a Covered child, this includes a medically diagnosed congenital defect), it is ordered by a Physician and You have been Hospitalized or have undergone surgery for such illness or Injury.

Covered Services must begin within six months of the later to occur:

*Preauthorization required for certain services

- the date of the injury or illness that caused the need for the therapy;
- the date the Participant is discharged from a Hospital where surgical treatment was rendered; or
- the date outpatient surgical care is rendered.

And in no event will the therapy continue beyond 365 days after such event.

(7) RECONSTRUCTIVE BREAST SURGERY*

The Plan Covers breast reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by you and your attending Physician to be appropriate. The Plan also covers implanted breast prostheses following a mastectomy or partial mastectomy.

Breast reconstruction (including surgery on the healthy breast to restore and achieve symmetry) or implanted breast prostheses are also Covered following a Covered mastectomy. Cosmetic surgery is not Covered.

(8) OTHER RECONSTRUCTIVE AND CORRECTIVE SURGERY*

Reconstructive and corrective surgery is Covered only when it is:

- performed to correct a congenital birth defect of a child Covered under this Plan which has resulted in a functional defect;
- incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part;
- otherwise Medically Necessary.

The reconstructive or corrective surgery must be performed within two years of the surgery that was necessitated by the trauma, infection or disease.

Breast reconstruction (including surgery on the healthy breast to restore and achieve symmetry) or implanted breast prostheses are also Covered following a Covered mastectomy. Cosmetic surgery is not Covered.

(9) ORAL SURGERY

General dental services are not Covered. The following limited dental and oral surgical procedures are Covered in either an inpatient or outpatient setting:

- oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is Covered only when the repair is not possible. Dental services must be obtained within 12 months of the injury. Accidental injury does not include damage caused to a tooth while biting or chewing or the intentional misuse of the tooth.
- oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not Covered.
- surgical/nonsurgical medical procedures for temporomandibular joint disorders (TMJ) and orthognathic surgery. Preauthorization is required.

Oral Surgery, including the dental services described above, requires Preauthorization. When possible, please obtain the Preauthorization at least 14 days in advance of the surgery or procedure.

(10) LABORATORY PROCEDURES, DIAGNOSTIC TESTING, RADIOLOGY SERVICES AND X-RAY EXAMINATIONS

The Plan covers x-ray and laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services when performed on an outpatient basis.

Major diagnostic procedures require Preauthorization

It is important that you do not seek the services of a laboratory or imaging center without Preauthorization. If you do, you will be responsible for the costs of such services. Please contact Oxford before you obtain any of the procedures listed in the *Oxford Highlights*.

Screening for Prostate Cancer

The Plan covers an annual standard

*Preauthorization required for inpatient admissions

diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. The Plan also covers standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer. This benefit is not subject to Co-Payments, Deductibles or Coinsurance when provided by a Participating Provider.

(11) INTERNAL AND EXTERNAL PROSTHETIC DEVICES

Internal Prosthetic Devices

The Plan covers surgically implanted prosthetic devices and special appliances will be Covered if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear. Coverage does not include artificial organs.

External Prosthetic Devices

The Plan covers prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. The Plan covers wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). The Plan does not cover wigs made from human hair unless You are allergic to all synthetic wig materials.

The Plan does not cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly. For your other dental benefits, see the Motion Picture Industry Health Plan SPD for Active Participants or for Retired Participants.

Eyeglasses and contact lenses are not Covered under this Benefit. For your other vision benefits, see the Motion Picture Industry Health Plan SPD for Active Participants or for Retired Participants.

The Plan does not cover orthotics (e.g., shoe inserts).

For adults, The Plan covers the cost of only one prosthetic device, per limb, per lifetime. For children, the cost of replacements is also Covered but only if the previous device has been outgrown.

Coverage is for standard equipment only. The Plan does not otherwise cover the cost of repairs or replacement.

For adults, The Plan covers the cost of only one prosthetic device, per limb, per lifetime. For children, the cost of replacements is also Covered but only if the previous device has been outgrown.

The Plan covers external breast prostheses following a Covered mastectomy, which are not subject to any lifetime limit.

(12) DURABLE MEDICAL EQUIPMENT AND BRACES**

Durable Medical Equipment

The Plan covers the rental or purchase of durable medical equipment and braces. Durable Medical Equipment is equipment which is:

- designed and intended for repeated use;
- primarily and customarily used to serve a medical purpose;
- generally not useful to a person in the absence of disease or injury; and
- appropriate for use in the home.

Coverage is for standard equipment only. Repairs or replacement are Covered when made necessary by normal wear and tear. The Plan does not cover the cost of repairs or replacement that are the result of misuse or abuse by You. Oxford will determine whether to rent or purchase such equipment.

Customized or motorized equipment, or equipment designed for Your comfort or convenience (such as pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment) are not Covered as they do not meet the definition of durable medical equipment. The Plan does not cover customization of any item of Durable Medical Equipment.

Braces

The Plan covers braces that are worn externally and that temporarily or permanently assists all or part of an external body part function that has been lost or damaged because of an injury, disease or defect. Coverage

**Preauthorization is required for the purchase of Durable Medical Equipment or braces is required when the item will cost $500.00 or more.

is for standard equipment only. Replacements are Covered when growth or a change in the Participant's medical condition make replacement Medically Necessary. The Plan does not otherwise cover the cost of repairs or replacement (e.g., the Plan does not cover repairs or replacement that is the result of misuse or abuse by the Participant).

(13) MEDICAL SUPPLIES

The Plan covers medical supplies that are required for the treatment of a disease or injury which is Covered under the Supplemental SPD. Maintenance supplies (e.g., ostomy supplies) for conditions Covered under the Supplemental SPD. All such supplies must be Medically Necessary and in the appropriate amount for the treatment or maintenance program in progress. The Plan does not cover over-the-counter medical supplies. Diabetic Supplies are not Covered under this provision. Please see the "Diabetic Supplies, Education and Self-Management" section of the Supplemental SPD for a description of diabetic supply coverage.

(14) TRANSPLANTS

The Plan covers only those transplants that Oxford determines to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants (including CAR-T cell therapy for malignancies) for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome.

All transplants must be prescribed by your Specialist(s) and Preauthorized by Oxford's Medical Director. Additionally, all transplants must be performed at Hospitals that Oxford has specifically approved and designated to perform these procedures.

The Plan will cover the Hospital and medical expenses, including donor search fees, of the recipient. The Plan will cover transplant services required by a Participant when the Participant serves as an organ donor only if the recipient is a Participant. The Plan does not cover medical expenses of a non-Participant acting as a donor for a Participant are not Covered if the non-Participant's expenses will be Covered under another health plan or program. Donor costs related to transplantation are Covered Health Care Services and are payable through the organ recipient's coverage under the Plan, limited to donor: (i) identification, (ii) evaluation, (iii) organ removal, (iv) direct follow-up care.

The Plan will cover autologous bone marrow transplants combined with high dose chemotherapy when medically appropriate, for the treatment of: advance neuroblastoma, second remission acute leukemia, relapsed Hodgkin's disease, relapsed non-Hodgkin's lymphoma, and metastatic breast cancer or any other diagnosis that Oxford determines to be appropriate. Oxford will make the determination of when such treatment is medically appropriate.

The Plan does not cover travel expenses, lodging, meals or other accommodations for donors or guests; donor fees in connection with organ transplant surgery; or routine harvesting and storage of stem cells from newborn cord blood.

(15) HOME HEALTH CARE*

The Plan covers care provided in your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided by Physician-supervised health professionals pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility.

Home care includes:

- part-time or intermittent nursing care by or under the supervisions of a registered professional nurse (RN),
- part-time or intermittent services of a home health aide,
- physical, occupational, or speech therapy provided by the Home Health Agency, and
- medical supplies, drugs and medications prescribed by an In-Network Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility.

Each visit up to four hours by a Home Health Agency is considered one visit. Each visit of up to four hours by a home health aide is one visit. Refer to your Schedule of Benefits to determine if a limit applies to your Plan.

Note

Any rehabilitation services received under this benefit will not reduce the amount of services available under "Rehabilitation Services".

(16) CHEMOTHERAPY*

The Plan covers Chemotherapy

*Preauthorization required

in an outpatient Facility or in a health care professional's office. When Chemotherapy is provided in the office, Preauthorization is not required. See *Hospital and Other Facility-Based Services*, under the heading *Hospital Services* for inpatient coverage.

(17) SECOND OPINIONS

The Plan covers a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from an Out-of-Network Provider on an In-Network basis when your attending Physician provides a written Referral to an Out-of-Network Specialist.

Second Surgical Opinion

The Plan covers a second surgical opinion by a qualified Physician on the need for surgery.

Required Second Surgical Opinion

Oxford reserves the right to require a second opinion for any surgical procedure. At the time of Preauthorization, you may be advised that a second opinion will be required in order for the services to be Covered. The second opinion must be given by a board certified Specialist who personally examines you. If the first and second opinions do not agree, you may obtain a third opinion. There is no cost to you when Oxford requests a second opinion.

In the event that the first and second opinions differ, you may obtain a third opinion. The second and third surgical opinion consultants may not perform the surgery on you.

Second Opinions in Other Cases

There may be other instances when you will disagree with a Provider's recommended course of treatment. In such cases, you may request that Oxford designate another Provider to render a second opinion. If the first and second opinions do not agree, Oxford will designate another Provider to render a third opinion. After completion of the second opinion process, Oxford will Preauthorize Covered Services supported by a majority of the Providers reviewing your case.

(18) CHIROPRACTIC SERVICES

The Plan will cover spinal subluxation and related services when performed by a doctor of chiropractic ("Chiropractor"). This includes assessment, manipulation and any modalities.

This benefit remains subject to Medically Necessity. Any Medically Necessary laboratory tests will be Covered in accordance with the terms and conditions of the Supplemental SPD.

(19) CLINICAL TRIALS FOR CANCER OR DISABLING OR LIFE THREATENING CHRONIC DISEASE

The Plan will cover the routine patient costs associated with a qualifying clinical trial for cancer or a disabling or life-threatening chronic disease.

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

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

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

Routine patient care costs for qualifying clinical trials include:

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

*Preauthorization required

Routine costs for clinical trials do not include:

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

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - *National Institutes of Health (NIH).* (Includes *National Cancer Institute (NCI)*.)
  - *Centers for Disease Control and Prevention (CDC).*
  - *Agency for Healthcare Research and Quality (AHRQ).*
  - *Centers for Medicare and Medicaid Services (CMS).*
- A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA).*
- A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
- The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
  - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health.*
  - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration.*
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. Oxford may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Care Service and is not otherwise excluded under the Plan.

Please remember

The Covered Service must be Preauthorized.

(20) HEARING AIDS

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

Covered services are available for a hearing aid that is purchased as a result of a written recommendation by a Physician and include the hearing aid and the charges for associated fitting and testing. The Plan covers a single purchase (including repair and/or

replacement) of hearing aids for one or both ears once every three years.

Bone anchored hearing aids are Covered only if You have either of the following:

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

If you meet the criteria for a bone anchored hearing aid, coverage is provided for one hearing aid per ear during the entire period of time the You are enrolled under this Supplement. Replacements and/or repairs for a bone anchored hearing aid are Covered only for malfunctions.

(21) DIALYSIS

The Plan covers dialysis treatments of an Acute or chronic kidney ailment.

(22) GENDER DYSPHORIA*

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

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses are provided as described under Mental Health Services in your SPD.
- Cross-sex hormone therapy:
  - Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is provided under Physician-Administered Pharmaceuticals in your SPD.
- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:
  - Bilateral mastectomy or breast reduction
  - Clitoroplasty (creation of clitoris)
  - Hysterectomy (removal of uterus)
  - Labiaplasty (creation of labia)
  - Metoidioplasty (creation of penis, using clitoris)
  - Orchiectomy (removal of testicles)
  - Penectomy (removal of penis)
  - Penile prosthesis
  - Phalloplasty (creation of penis)
  - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
  - Scrotoplasty (creation of scrotum)
  - Testicular prosthesis
  - Urethroplasty (reconstruction of urethra)
  - Vaginectomy (removal of vagina)
  - Vaginoplasty (creation of vagina)
  - Vulvectomy (removal of vulva)

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements

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

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

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

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered person. The assessment must document that the Covered person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.
  - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
  - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).
- The treatment plan is based on identifiable external sources including the World Professional Association for Transgender

*Preauthorization required for Gender Dysphoria treatment

Health (WPATH) standards, and/or evidence-based professional society guidance.

(23) CELLULAR AND GENE THERAPY

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

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

(C) HOSPITAL AND OTHER FACILITY-BASED SERVICES

Please remember, in order to receive coverage for any facility based Covered Service, the Covered Service must be Preauthorized.

(1) HOSPITAL SERVICES*

All Preauthorized admissions to In-Network Hospitals are Covered on an In-Network basis; regardless of whether or not the admitting Provider is an In-Network Provider.

Inpatient Services

Coverage Hospital Inpatient services for Medically Necessary, acute-care includes: semi-private room and board, unlimited days, general nursing care and the following additional facilities, services and supplies: meals and special diets; use of operating room and related facilities; use of intensive care or cardiac care units and related services; x-ray services; laboratory and other diagnostic tests; drugs; medications; biologicals; anesthesia and oxygen services; short-term physical, speech and occupational therapy; radiation therapy; inhalation therapy; chemotherapy; whole blood and blood products; and the administration of whole blood and blood products.

Inpatient Stay for Lymph Node Dissection or Lumpectomy

The Plan will cover Hospital inpatient services for Participants undergoing a lymph node dissection or lumpectomy. Coverage is available for the period of time determined to be Medically Necessary by you and your Physician.

Autologous Blood Banking Services

Autologous blood banking services are Covered only when they are being provided in connection with a scheduled, Covered inpatient procedure for the treatment of a disease or injury. In such instances, the Plan will cover storage fees for what Oxford determines to be a reasonable storage period that is Medically Necessary and appropriate for having the blood available when it is needed.

Routine harvesting and storage of Stem Cells from newborn cord blood is not Covered.

Outpatient Services

The Plan covers the inpatient Hospital services and supplies listed previously that can be provided to you while being treated in the outpatient facility.

Please remember

Unless you are receiving preadmission testing, In-Network Hospitals are not In-Network Providers for laboratory procedures and tests.

Note

Lab work and x-rays performed in a hospital on an outpatient basis do not require Preauthorization.

(2) AMBULATORY SURGERY CENTER

Coverage is available for Covered surgical procedures performed at Ambulatory Surgical Centers. The Plan also covers the Covered Services and supplies provided by the Center the day the surgery is performed.

(3) SKILLED NURSING FACILITY**

The Plan covers non-custodial services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. In addition to Preauthorization, an admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by your Provider and approved by Oxford. The Plan covers noncustodial care for the amount of days shown in the *Oxford Highlights*. Coverage is limited to 100 days per calendar year.

(4) HOSPICE***

Hospice Care is available to Participants who have a prognosis of six months or less to live. Coverage consists of palliative care rather than curative treatment. The Plan covers a total of 5 visits for supportive care and guidance for the purpose of helping the Participant and the Participant's immediate family cope with the emotional and social issues related to the Participant's death. Hospice Care will be Covered only when provided as part of a Hospice Care program certified by the appropriate state agency. Such certified programs may include Hospice Care delivered by: a Hospital (inpatient or outpatient), Home Health Care Agency, Skilled

*Hospital admissions require Preauthorization.
**This benefit requires Preauthorization and treatment plan.
***This benefit requires Preauthorization for services rendered inpatient or in the home.

Nursing Facility or a licensed Hospice facility.

Coverage is not provided for:

- funeral arrangements,
- pastoral, financial or legal counseling;
- homemaker, caretaker or respite care.

D EMERGENCIES

In order to obtain coverage for Emergencies, you should follow the instructions below, regardless of whether or not you are in the Service Area at the time of the Emergency. Emergencies include Covered Services provided by any health care provider as outlined below:

The Plan defines an Emergency as follows: a serious medical condition or symptom resulting from Injury, Sickness or mental illness, or substance-related and addictive disorders which: (a) arise suddenly; and (b) in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

With respect to a pregnant Participant who is having contractions, an emergency exists where: there is inadequate time to affect a safe transfer to another Hospital before delivery; or the transfer may pose a threat to the health or safety of the mother or the unborn child.

Emergencies include, but are not limited to, the following conditions:

- severe chest pains
- severe shortness of breath
- severe or multiple injuries
- loss of consciousness
- convulsions
- severe bleeding
- poisonings
- sudden change in mental status (e.g., disorientation)
- acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis

Oxford reserves the right to review all appropriate medical records and make the final decision regarding the existence of an Emergency. Regarding such retrospective reviews, the Plan will cover only those services and supplies that are Medically Necessary and are performed to treat or stabilize an Emergency condition.

1 HOSPITAL EMERGENCY ROOM VISITS

In the event of an emergency, seek immediate care at the nearest emergency room or call 911.

Emergency room care is not subject to Oxford's prior approval. However, only emergencies, as defined above, are covered in an emergency room. If you would like assistance assessing the situation, you may call your In-Network Provider (if applicable). You can also call Oxford's Medical Management Coordinators or *Oxford-On-Call*. They are available 24 hours a day, 7 days a week. Your In-Network Provider or *Oxford-On-Call* will direct you to the emergency room of a hospital or other appropriate facility.

Follow-up care provided in a hospital emergency room is not covered.

2 EMERGENCY HOSPITAL ADMISSIONS

In the event you are admitted to the Hospital, you or someone on your behalf must notify Oxford at the Emergency telephone number listed in the front of the Supplemental SPD within 48 hours of your admission, or as soon as is reasonably possible.

It is important to remember that only those conditions that meet all of the requirements contained in the definition of Emergency will be Covered as an Emergency. Routine care received in an emergency room is not Covered.

3 AMBULANCE SERVICES****

Ambulance services for life-threatening Emergencies will be Covered. Ambulance services for all other Emergencies will be Covered when Medically Necessary.

The Plan also covers pre-hospital emergency medical services. This means the Plan covers the prompt evaluation and treatment of an Emergency in addition to non-air-borne transportation of the patient.

Inter-facility ambulance transfers will also be Covered if they receive Preauthorization.

4 PAYMENTS RELATING TO EMERGENCY SERVICES RENDERED

The amount the Plan pays an Out-of-Network Provider for Emergency Services will be the greater of:

- the amount the Claims Administrator has negotiated with Participating Providers for the Emergency Service received (and if more than one amount is negotiated, the median of the amounts);
- 100% of the Allowable Amounts for Services provided by an Out-of-Network Provider (i.e., the amount the Claims Administrator would pay in the absence of any Cost-Sharing

***This benefit requires Preauthorization for services rendered inpatient or in the home.
****This benefit may require Preauthorization

that would otherwise apply for services of Out-of-Network Providers); or

- the amount that would be paid under Medicare. The amounts described above exclude any Co-Payment or Coinsurance that applies to Emergency Services provided by a Participating Provider.

You are responsible for any Deductible, Coinsurance or Co-Payment.

(5) URGENT CARE

The Plan defines Urgent Care as medical care for a condition that needs immediate attention to minimize severity and prevent complications, but is not an Emergency. Urgent Care is Covered in or out of the Service Area.

If an Urgent Care visit results in an emergency admission, please follow the instructions for Emergency Hospital Admissions described above.

Reimbursement and Co-Payments

When you receive Covered Services for an Emergency or Urgent Care situation from an Out-of-Network Provider, outside of the Service Area, the Plan will limit reimbursement to the Usual, Customary and Reasonable Charges for those expenses incurred up to the time the Participant is determined to be able to travel to an In-Network Provider. The Out-of-Network Reimbursement Amount is the amount charged or the amount Oxford determines to the reasonable charge, whichever is less, for a particular Covered Service in the geographical area it is performed. Additionally, reimbursement is subject to all applicable Co-Payments as similar services provided by an In-Network Provider.

(E) MENTAL HEALTH CARE AND SUBSTANCE-RELATED AND ADDICTIVE DISORDER SERVICES

(1) MENTAL HEALTH CARE SERVICES

Inpatient Services

The Plan covers inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders comparable to other similar Hospital, medical, and surgical coverage provided under the Supplemental SPD. Coverage for inpatient services for mental health care is limited to Facilities such as:

- a psychiatric center or inpatient Facility;
- a state or local government run psychiatric inpatient facility;
- a part of a Hospital providing inpatient mental health care services;
- a comprehensive psychiatric emergency program or other Facility providing inpatient mental health care.

The Plan also covers inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities and to residential treatment facilities that are licensed or certified under applicable law.

Outpatient Services

The Plan covers outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to applicable law or are operated by the Office of Mental Health and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker who has at least three years of additional experience in psychotherapy; a licensed mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst or a professional corporation or a university faculty practice corporation thereof.

Limitations/Terms of Coverage

Oxford does not cover:

- benefits or services deemed to be cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs;
- mental health benefits or services for individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth; or
- services solely because they are ordered by a court.

(2) SUBSTANCE USE SERVICES

Inpatient Services

The Plan covers inpatient substance-related and addictive disorder services relating to the diagnosis and treatment of

alcoholism, substance-related and addictive disorders. This includes coverage for detoxification and rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance-related and addictive disorders are limited to those Facilities that are licensed or certified by a state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

The Plan also covers inpatient substance-related and addictive disorders relating to the diagnosis and treatment of alcoholism, substance use and dependency received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is to those Facilities that are licensed or certified by a state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

Outpatient Services

The Plan covers outpatient substance-related and addictive disorders relating to the diagnosis and treatment of alcoholism, substance-related and addictive disorders, including but not limited to partial hospitalization program service, intensive outpatient program service, and methadone treatment. Such coverage is limited to Facilities to those that are licensed or certified by a state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance-related and addictive disorders relating to the diagnosis and treatment of alcoholism, substance-related and addictive disorders or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

The Plan also covers up to 20 outpatient visits per calendar year for family counseling. A family member will be deemed to be Covered, for the purposes of this provision, so long as that family member:

- identifies himself or herself as a family member of a person suffering from substance-related and addictive disorders and/or dependency, and
- is Covered under the same Plan that covers the person receiving, or in need of, treatment for substance-related and addictive disorders, and/or dependency. Plan payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

(3) NEUROBIOLOGICAL DISORDERS - AUTISM SPECTRUM DISORDER SERVICES

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

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

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

SECTION 6

Exclusions And Limitations

Unless coverage is specifically provided under the Supplemental SPD or provided under a rider or attachment to the Supplemental SPD, the following services and benefits are not Covered.

1 AVIATION

The Plan does not cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

2 SERVICES WHICH ARE NOT MEDICALLY NECESSARY

If there is a dispute between a Provider and Oxford about the Medical Necessity of a service or supply, you or your Provider may appeal Oxford's decision. Any disputed service or supply will not be Covered during the appeal process.

3 ACUPUNCTURE THERAPY

4 ADOPTED NEWLY BORN INFANT'S HOSPITAL STAY

An adopted newly born infant's initial hospital stay if the natural parent has coverage available for the infant's care.

5 BLOOD, BLOOD PLASMA AND BLOOD DERIVATIVES

Blood, blood plasma and blood derivatives other than those described as Covered Services. Synthetic blood, apheresis or plasmapheresis, the collection and storage of blood, and the cost of securing the services of blood donors are not Covered.

6 BIRTH CONTROL

Birth control pills, implantable or injectable contraceptive drugs, condoms, foams or devices, (except intrauterine device (IUD) which are covered effective January 1, 2023, diaphragms, contraceptive jellies and ointments, even if they are being prescribed or recommended for a medical condition other than birth control. If the Plan has purchased "Outpatient Prescription Drug" coverage, some of these items may be Covered.

7 TREATMENT IN AN OUT-OF-NETWORK FEDERAL, STATE OR OTHER GOVERNMENTAL ENTITY HOSPITAL

To the extent allowed by law, the Plan does not cover care or treatment provided in an Out-of-Network Hospital that is owned or operated by any federal, state or other governmental entity.

8 TREATMENT IN A PUBLIC FACILITY

Care for conditions that by federal, state or local law must be treated in a public facility including, but not limited to, commitments for mental illness. Additionally, to the extent allowed by law, the Plan does not cover care or treatment provided in an Out-of-Network Hospital that is owned or operated by any federal, state or other governmental entity.

9 COMFORT OR CONVENIENCE ITEMS

Comfort or convenience items including, but not limited to: barber services; guest meals and accommodations; telephone, television or radio charges; travel expenses; or take-home supplies. The Plan also does not cover the purchase or rental of household fixtures or equipment including, but not limited to: escalators; elevators; swimming pools; exercise cycles; treadmills, weight training or muscle strengthening equipment; air purifiers; air conditioners; water purifiers; allergenic pillows, mattresses or waterbeds.

10 COSMETIC, RECONSTRUCTIVE OR PLASTIC SURGERY

Cosmetic, reconstructive or plastic surgery that is done for a condition that does not meet the specific criteria stated in "Reconstructive and Corrective Surgery," including but not limited to: cosmetic surgery, plastic or reconstructive surgery which is performed primarily to improve the appearance of any portion of the body including but not limited to: surgery for sagging or extra skin; any augmentation or reduction procedure (e.g., mammoplasty); liposuction; rhinoplasty and rhinoplasty done in conjunction with Covered nasal or Covered sinus surgery. Complications of such surgeries are Covered only if they are Medically Necessary and are otherwise Covered. Remedial work is not Covered.

11 COURT ORDERED SERVICES

Court ordered services or services that have been ordered as a condition of probation or parole. However, these services may be Covered if Oxford agrees that the services are Medically Necessary, are otherwise Covered, the Participant

has not exhausted their benefit for the contract/calendar year, and the treatment is provided in accordance with our policies and procedures.

⓬ CONVALESCENT AND CUSTODIAL CARE

The Plan does not cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

⓭ CONVERSION THERAPY

The Plan does not cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

⓮ COSMETIC SERVICES

Cosmetic, Prescription Drugs, or reconstructive or plastic surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a Covered Child which has resulted in a functional defect. The Plan also covers services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in the Supplemental SPD. Cosmetic surgery does not include surgery determined to be Medically Necessary.

⓯ DENTAL SERVICES

The Plan does not cover dental services for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment as specifically stated in the Outpatient and Professional Services section of the Supplemental SPD.

⓰ CERTAIN DIABETIC SERVICES OR SUPPLIES

The following are not Covered as diabetic services or supplies:

- services or supplies that are not both Medically Necessary and prescribed by the Participant's Physician or qualified health professional;
- membership in health clubs, diet plans or clubs even if recommended by a Physician or any other provider for purpose of losing weight;
- any counseling or courses in diabetes management other than as described as Covered under the Supplemental SPD;
- stays at special facilities or spas for the purpose of diabetes education/management;
- special foods, diet aids and supplements related to dieting.

⓱ CERTAIN DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment (other than as specifically Covered under the Supplemental SPD. The Plan also does not cover: TENS units (except as Covered under Durable Medical Equipment); blood pressure monitoring devices; car seats; arch supports; cervical collars; corrective shoes; false teeth; tilt tables; electronic communication devices; in-flight oxygen for non-emergency travel; special supplies or equipment; or special appliances.

⓲ EXPERIMENTAL OR INVESTIGATIONAL TREATMENT

The Plan does not cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational.

⓳ IMPROPER USE OF AN EMERGENCY ROOM OR EMERGENCY ADMISSIONS

Routine care and treatment for conditions that Oxford determines were not Emergencies, when received in an emergency room, are not Covered.

⓴ INFERTILITY TREATMENTS AND SUPPLIES

Except as otherwise Covered under the Supplemental SPD, even if the treatment or supply is for a purpose other than the correction of infertility. The following services and supplies are not Covered:

- cost for an ovum donor or donor sperm, sperm storage costs, chromosomal analyses, testicular biopsy, elective abdominal surgeries related to lysis of adhesions or asymptomatic varicoceles, radiographic imaging to determine tubal patency;
- blood analyses related to immunological diagnosis of infertility, cryopreservation and storage of embryos (unless the Participant has not yet reached her lifetime limit of four egg retrievals), in-vitro services for women who have undergone tubal ligation, any infertility services if the male has undergone a vasectomy and the following services related to a Gestational Carrier or Surrogate (i) Fees for the use of a Gestational Carrier or Surrogate (ii) Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.
- the Plan also does not cover services to reverse voluntary sterilization. Treatment of an underlying medical condition will not be denied (if the treatment is otherwise Covered under the Supplemental SPD) solely because the medical condition results in infertility.

21 LEARNING AND BEHAVIORAL DISORDERS

Services for the evaluation or treatment (including remedial education) of:

- learning disabilities or minimal brain dysfunction;
- mental retardation;
- developmental and learning disorders or behavioral problems.
- the Plan also does not cover behavioral training, visual perceptual or visual motor training related to learning disabilities or cognitive rehabilitation.
- Behavioral and learning disorders related to congenital abnormalities such as Down's Syndrome are not Covered.

22 SERVICES AND TREATMENT IN GOVERNMENT FACILITY

Services and treatment provided in a government facility, i.e., military services-related injuries.

23 NO-FAULT AUTOMOBILE INSURANCE

Any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

24 NON-ELIGIBLE INSTITUTIONS

Any services or supplies furnished by a non-eligible institution, which is defined as other than a Hospital or Skilled Nursing Facility, and which is primarily a place of rest, a place for the aged, or any similar institution, regardless of how denominated.

25 NON-MEDICAL SERVICES AND LONG-TERM REHABILITATION SERVICES

Non-medical services and long-term rehabilitation services for physical therapy or the treatment of alcoholism or drug abuse, including rehabilitation services in a specialized inpatient or residential facility, except as specifically Covered under the Supplemental SPD.

26 NO-SHOW CHARGES

If a Provider charges a fee for a missed appointment, you will be responsible for the payment of the fee.

27 OCCUPATIONAL CONDITIONS, AILMENTS, OR INJURIES

Occupational conditions, ailments, or injuries arising out of and in the course of employment. Such conditions, ailments or injuries are not Covered if they are subject to coverage, in whole or in part, under any workers' compensation, occupational disease or similar law. This applies even if the Participant's rights have been waived or qualified.

28 OUTPATIENT PRESCRIPTION DRUGS

Outpatient Prescription Drugs, unless coverage has been purchased by the Plan. For the outpatient prescription drug benefits available to you through CVS Caremark, see the Motion Picture Industry Health Plan SPD for Active Participants and for Retired Participants.

29 SELF-INJECTABLE MEDICATIONS

This exclusion does not apply to drugs for the treatment of diabetes and medications which, due to their characteristics (as determined by Oxford), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.

30 NON-INJECTABLE MEDICATIONS GIVEN IN A PHYSICIAN'S OFFICE

This exclusion does not apply to

non-injectible medications that are required in a Medical Emergency and consumed in the Physician's office.

31 OVER-THE-COUNTER DRUGS AND TREATMENTS

32 GROWTH HORMONE THERAPY

33 BIOSIMILAR PHARMACEUTICAL PRODUCTS

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

34 CERTAIN PHARMACEUTICAL PRODUCTS

Certain pharmaceutical products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by Oxford. Such determinations may be made up to six times during a calendar year.

35 NEW FDA-APPROVED PRESCRIPTION MEDICATIONS OR PRODUCTS

New U.S. Food and Drug Administration (FDA)-approved prescription medications or products administered in connection with a Covered Health Care Service by a Physician and/or new dosage forms until the date they are reviewed.

36 PRIVATE OR SPECIAL DUTY NURSING

37 REHABILITATION SERVICES OR PHYSICAL THERAPY ON A LONG-TERM BASIS

Speech or occupational therapy to correct a condition that is not the result of a disease, injury or a congenital defect for which surgery has been performed.

38 ROUTINE FOOT CARE

Routine foot care including nail trimming, corn and callous removal, cleaning, soaking or any other hygienic maintenance or care. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

39 SERVICES OUTSIDE LIMIT

Services for which the day or visit limit identified in the Oxford Highlights has been met.

40 CERTAIN PSYCHIATRIC SERVICES

Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Associate*.

41 COURT-ORDERED SERVICES

Services, solely because such services are ordered by a court.

42 CERTAIN COUNSELING AND THERAPY SERVICES

Sex, marital or religious counseling, including sex therapy and treatment of sexual dysfunction.

43 SPECIAL FOODS, DIETS, SUPPLEMENTS AND FEEDINGS

Special foods and diets, supplements, vitamins and enteral feedings, except as what is otherwise outlined in the Supplemental SPD. When coverage of special foods, diets and enteral feedings are available, it is subject to periodic review for Medical Necessity. Infant formulas are not Covered.

44 SPECIAL MEDICAL REPORTS

Special medical reports not directly related to treatment. Appearances in court or at a hearing.

45 TEMPOROMANDIBULAR JOINT SYNDROME

Dental procedures and appliances for the treatment of temporomandibular joint syndrome or craniomandibular pain syndrome. Surgical and nonsurgical medical procedures are Covered if Preauthorized and approved by Oxford's Medical Director.

46 THIRD PARTY REQUESTS

Third party requests for physical examinations, diagnostic services and immunizations in connection with:

- obtaining or continuing employment;
- obtaining or maintaining any license issued by a municipality, state or federal government;
- obtaining insurance coverage; foreign travel;
- school admissions or attendance including examinations required for participation in athletic activities.
- Court ordered psychological

or behavioral evaluations or counseling related to marital disputes, divorce proceedings, or child custody proceedings are not Covered.

47 CERTAIN TRANSPLANT SERVICES

Transplant services required by a Participant when the Participant serves as an organ donor are not Covered unless the recipient is a Participant. The medical expenses of a non-Participant acting as a donor for a Participant are not Covered if the non-Participant's expenses will be Covered under another health plan or program. Donor fees in connection with organ transplant surgery are excluded. The Plan does not cover travel expenses, lodging, meals or other accommodations for donors or guests. Transplants performed in facilities other than those designated by Oxford for the transplant procedure are not Covered.

48 TREATMENT FOR INCARCERATED OR COMMITTED INDIVIDUALS

Treatment provided in connection with services for individuals who are presently incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by the office of children and family services.

49 COVERAGE OUTSIDE OF THE UNITED STATES

No coverage is available outside of the United States if the Participant traveled out of-the-country to obtain medical treatment, drugs or supplies. Additionally, the Plan will not cover any treatment, drugs or supplies that are unavailable or illegal in the United States.

When a Participant is traveling for other purposes, only Emergencies and Urgent Care will be Covered outside of the United States (with the exception of Canada, Mexico and U.S. possessions)

50 UNNECESSARY CARE

In general, the Plan will not cover any health care service that in Oxford's sole judgment, determines is not Medically Necessary.

51 CERTAIN OUT-OF-NETWORK CHARGES

Any charges by an Out-of-Network Provider for Covered Services that are in excess of Oxford's Fee Schedule are excluded from coverage and are the Participant's responsibility.

52 EYEGLASSES AND EYEGLASS EXAMINATIONS

Eyeglasses and examination for the prescription of fitting thereof, unless added through supplemental coverage.

53 CERTAIN WIGS OR HAIR LOSS TREATMENTS

Wigs, or any other appliance or procedure related to hair loss regardless of the disease or injury causing the hair loss (except following chemotherapy).

54 WEIGHT CONTROL

All services, supplies, programs and surgical procedures for the purpose of weight control.

55 ANY SERVICE, SUPPLY OR TREATMENT NOT SPECIFICALLY LISTED AS A COVERED SERVICE, SUPPLY OR TREATMENT

Any supply or treatment for which the Participant has no legal obligation to reimburse the Provider. Any supply or treatment provided by a Participant of the Participant's family (mother, step-mother, father, stepfather, sister, step-sister, brother, step-brother, any "in-law," aunt, uncle, niece, nephew or cousin).

56 SERVICES PROVIDED BY A FAMILY MEMBER

The Plan does not cover services performed by a member of the Covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister, or brother of you or your spouse.

57 MEDICARE OR OTHER GOVERNMENT PROGRAM

The Plan does not cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid). When You are eligible for Medicare the Plan will reduce Your benefits by the amount Medicare would have paid for the Covered Services. Except as otherwise required by law, this reduction is made even if You fail to enroll in Medicare or You do not pay Your Medicare Premium. Benefits for Covered Services will not be reduced if the Plan is required by federal law to pay first or if You are not eligible for premium-free Medicare Part A.

58 CERTAIN CELLULAR AND GENE THERAPY SERVICES

Cellular and Gene Therapy services not received from a Designated Provider.

59 GENDER DYSPHORIA

Cosmetic Procedures, including the following:

- Abdominoplasty.
- Blepharoplasty.

- Body contouring, such as lipoplasty.
- Brow lift.
- Calf implants.
- Cheek, chin, and nose implants.
- Injection of fillers or neurotoxins.
- Face lift, forehead lift, or neck tightening.
- Facial bone remodeling for facial feminizations.
- Hair removal, except as part of a genital reconstruction procedure by a physician for the treatment of gender Dysphoria.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.

60 AUTISM SPECTRUM DISORDERS

Except as specifically provided under this Summary Plan Description:

- services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
- any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore are considered Experimental or Investigational.
- mental retardation as the primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- relational problems as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.
- learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder.
- treatments for the primary diagnosis of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias and other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by Oxford.
- services or supplies for the diagnosis or treatment of mental illness that, in Oxford's reasonable judgment, are not Medically Necessary or are any of the following:
  - not consistent with generally accepted standards of medical practice for the treatment of such conditions.
  - not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore are considered Experimental or Investigational.
  - typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
  - not consistent with Oxford's level of care guidelines or best practices as modified from time to time.
  - not clinically appropriate in terms of type frequency, extent, site and duration of treatment, and considered ineffective for the patient's mental illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

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

61 MENTAL HEALTH SERVICES

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- Mental Health Services as treatment for a primary diagnosis of sexual dysfunction disorders.
- Treatments for the primary diagnoses of learning disabilities.
- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social

interaction and learning.

- ► Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.
- ► Learning, motor skills and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- ► Mental retardation as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- ► Relational problems as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- ► Services or supplies for the diagnosis or treatment of Mental Illness that, in Oxford's reasonable judgment, are not Medically Necessary or are any of the following:
  - – not consistent with generally accepted standards of medical practice for the treatment of such conditions.
  - – not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore are considered Experimental or Investigational.
  - – typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
  - – not consistent with Oxford's level of care guidelines or best practices as modified from time to time.
  - – not clinically appropriate in terms of type frequency, extent, site and duration of treatment, and considered ineffective for the patient's mental illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

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

62 SUBSTANCE-RELATED AND ADDICTIVE DISORDERS

- ► Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
- ► Substance-Related and Addictive Disorder Services for the treatment of caffeine use.
- ► Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
- ► Services or supplies for the diagnosis or treatment of substance-related and addictive disorders that, in Oxford's reasonable judgment, are not Medically Necessary or are any of the following:
  - – not consistent with generally accepted standards of medical practice for the treatment of such conditions.
  - – not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore are considered Experimental or Investigational.
  - – not consistent with Oxford's level of care guidelines or best practices as modified from time to time.
  - – not clinically appropriate and considered ineffective for the patient's Mental Illness, substance-related and addictive disorders or condition based on generally accepted standards of medical practice and benchmarks.

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

SECTION 7

Participant Rights And Responsibilities

WHAT ARE MY RIGHTS AS A PARTICIPANT?

As a Participant you have the following rights:

1. The right to obtain complete and current information concerning a diagnosis, treatment and prognosis from any In-Network Provider in terms that you or your authorized representative can readily understand. You have the right to be given the name, professional status and function of any personnel delivering Covered Services to you.

   You have the right to receive all information from an In-Network Provider necessary for you to give your informed consent prior to the start of any procedure or treatment.

   You also have the right to refuse treatment to the extent permitted by law. Oxford and your PCP will make every effort to arrange a professionally acceptable alternative treatment. However, if you still refuse the recommended treatment and Oxford and your In-Network Provider believe no professionally acceptable alternative exists, Oxford will not be responsible for the cost of further treatment for that condition. You will be notified accordingly.

   If a Participant is not capable of understanding any of this information, an explanation will be provided to his or her guardian, designee or a family Participant.

2. The right to be provided with information about Oxford's services, policies, procedures, grievance and appeal procedures and Oxford's In-Network Providers that accurately provides relevant information in a manner that is easily understood.

3. The right to quality health care services, provided in a professional manner that respects your dignity and protects your privacy. You also have the right to participate in decision-making regarding your health care.

4. The right to privacy and confidentiality of your health records, except as otherwise provided by law or contract. You have the right to all information contained in your medical records unless access is specifically restricted by the attending physician for medical reasons.

5. The right to initiate disenrollment from the Plan.

6. The right to file a formal grievance or appeal if complaints or concerns arise about Oxford's medical or administrative services or policies.

7. The right, when Medically Necessary, to emergency care without unnecessary delay.

8. The right to be advised if any of the In-Network Providers participating in your care propose to engage in or perform human experimentation or research affecting your care or treatment. You or a legally responsible party on your behalf may, at any time, refuse to participate in or to continue in any experimentation or research program to which you have previously given informed consent.

9. The right to sign-language interpreter services in accordance with applicable laws and regulations, when such services are necessary to enable you as a person with special communication needs to communicate effectively with your provider.

WHAT ARE MY RESPONSIBILITIES?

Your Responsibilities Include:

1. To enter into this Plan with the intent of following the policies and procedures as outlined in the Supplemental SPD.

2. To take an active role in your health care through maintaining good relations with your Provider and following prescribed treatments and guidelines.

3. To provide, to the extent possible, information that professional staff need in order to care for you as a Participant.

4. To use the emergency room only as described in the Supplemental SPD.

5. To notify the proper Plan representative of any change in name, address or any other important information.

SECTION 8

Claims Procedures

WHAT THIS SECTION INCLUDES:

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

PARTICIPATING PROVIDER BENEFITS

In general, if you receive Covered Services from an In-Network provider, Oxford will pay the Physician or facility directly. If an In-Network provider bills you for any Covered Service other than your Co-payment or Coinsurance, please contact the provider or call the Customer Service phone number on your ID card for assistance.

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

If you receive Covered Services from a Participating Provider but not in accordance with the terms and conditions of the Supplemental SPD, coverage will be provided as described in the Supplemental SPD. When you see a Participating Provider under these circumstances, the Covered Services will be treated as if they were delivered by an Out-of-Network Provider, and you must file a claim as described below.

OUT-OF-NETWORK PROVIDER BENEFITS

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

HOW TO SUBMIT A CLAIM

You can obtain a claim form by visiting www.oxhp.com, calling the toll-free Customer Service number on your ID card or contacting your Plan Administrator. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below.

If any of these items are missing from the bill, you can include them in your letter:

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

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

For medical claims, the above information should be filed with Oxford at the address on your ID card.

Payment of Benefits

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

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

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

As a matter of convenience to

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

Any such payment to a provider:

- is NOT an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits; and
- is NOT a waiver of the prohibition on assignment of Benefits under the Plan; and
- shall NOT estop the Plan, Plan Sponsor, or Claims Administrator from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

If this direct payment for your convenience is made, the Plan's obligation to you with respect to such Benefits is extinguished by such payment. If any payment of your Benefits is made to a provider as a convenience to you, the Claims Administrator will treat you, rather than the provider, as the beneficiary of your claim for Benefits, and the Plan reserves the right to offset any Benefits to be paid to a provider by any amounts that the provider owes the Plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan), pursuant to Refund of Overpayments in Section 9: Coordination of Benefits.

Allowed Amounts due to an out-of-Network provider for Covered Health Care Services that are subject to the *No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260)* are paid directly to the provider.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that Oxford in its discretion determines to be adequate.

Limitations (Timeframe for Filing Claims)

All requests for reimbursement must be made within 120 days of the date Covered Services were rendered. Failure to request reimbursement within the required time will not invalidate or reduce any claim if it was not reasonably possible to provide such proof within the 120-day period. However, such request must be made as soon as reasonably possible thereafter. Under no circumstances will Oxford or the Plan be liable for a claim that is submitted more than six months after the date services were rendered, unless you are legally incapacitated and unable to submit the request. All reimbursements to Out-of-Network Providers are subject to an Out-of-Network Reimbursement Amount unless you were referred to an Out-of-Network Provider by your PCP or Oxford.

If You Receive a Bill from an In-Network Provider

The cost of Covered Services provided by In-Network Providers in accordance with the terms of the Supplemental SPD will be billed directly to Oxford. **No claim forms are necessary.**

If you should receive a bill from an In-Network Provider for Covered Services, please contact the Customer Service Department immediately.

Claim Information

If necessary, Oxford's Claims Department will contact you for more information regarding your claim in order to speed up the processing. If you would like to inquire about the status of a claim, call the "Claims" telephone number list in the front of the Supplemental SPD. Please have the date of service and your ID number ready.

EXPLANATION OF BENEFITS (EOB)

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

LIMITATION OF ACTION

You cannot bring any legal action against the Plan Administrator or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against the Plan Administrator or the Claims Administrator you must do so within 180 days of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Plan Administrator or the Claims Administrator.

CLAIM DENIALS AND APPEALS

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call

Oxford at the number on your ID card before requesting a formal appeal. If Oxford cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

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

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

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

Oxford
P.O. Box 30432
Salt Lake City, Utah 84130-0432

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

Types of Claims

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

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

Urgent Appeals that Require Immediate Action

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

Review of an Appeal

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

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

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

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from Motion Picture Industry Health Plan within 180 days from receipt of the first level appeal determination. You or your authorized representative may send a written request for a second level appeal to:

Motion Picture Industry Health Plan
Attn Benefits/Appeals Committee
P.O. Box 1999
Studio City, CA 91614

Note

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

Timing of Appeals Determinations

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

- **Urgent Care Request for Benefits**
  A request for benefits provided in connection with Urgent Care services, as defined in Section 13, *Glossary;*

- **Pre-Service Request for Benefits**
  A request for benefits which the Plan must approve or in which you must notify Oxford before non-Urgent Care is provided; and
- **Post-Service Claims**
  A claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables on pages 41 and 42 describe the time frames which you and Oxford are required to follow.

Concurrent Care Claims

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

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

URGENT CARE REQUEST FOR BENEFITS*

TYPE OF REQUEST FOR BENEFITS OR APPEAL	TIMING
If your request for benefits is incomplete, Oxford must notify you within:	**24 hours**
You must then provide completed request for benefits information to Oxford within:	**48 hours** after receiving notice of additional information required
Oxford must notify you of the benefit determination within:	**72 hours**
If Oxford denies your request for benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
Oxford must notify you of the appeal decision within:	**72 hours** after receiving the appeal

Please see the SPD for information about further appeals to the Motion Picture Industry Health Plan Benefits/Appeals Committee.

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

PRE-SERVICE REQUEST FOR BENEFITS*

TYPE OF REQUEST FOR BENEFITS OR APPEAL	TIMING
If your request for benefits is filed improperly, Oxford must notify you within:	**5 days**
If your request for benefits is incomplete, Oxford must notify you within:	**15 days**
You must then provide completed request for benefits information to Oxford within:	**45 days**
Oxford must notify you of the benefit determination, if the initial request for benefits is complete, within:	**15 days**
Oxford must notify you of the benefit determination, after receiving the completed request for benefits (if the initial request for benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
Oxford must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**180 days** after receiving the first level appeal decision
MPIHP must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

Please see the SPD for information about further appeals to the Motion Picture Industry Health Plan Benefits/Appeals Committee.

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

POST-SERVICE CLAIMS	
TYPE OF REQUEST FOR BENEFITS OR APPEAL	**TIMING**
If your claim is incomplete, Oxford must notify you within:	**30 days**
You must then provide completed claim information to Oxford within:	**45 days**
Oxford must notify you of the benefit determination, if the initial claim is complete, within:	**30 days**
Oxford must notify you of the benefit determination, after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
Oxford 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:	**180 days** after receiving the first level appeal decision
MPIHP must notify you of the second level appeal decision within:	**Generally within 60 days** after receiving the second level appeal*

Please see the SPD for information about further appeals to the Motion Picture Industry Health Plan Benefits/Appeals Committee.

*Appeals will generally be heard at the Benefits/Appeals Committee meeting that follows receipt of the appeal, if it is received more than 30 days in advance of the meeting. If received less than 30 days before the meeting, the appeal may be heard at the second meeting after such receipt. However, if special circumstances exist, the Benefits/Appeals Committee will inform the Participant of the need for a further extension, what those special circumstances are, and the date the appeal will be decided. You will be provided notice of the appeals decision within five days of the decision

Limitation of Action

You cannot bring any legal action against the Motion Picture Industry Health Plan or the Claims Administrator to recover reimbursement until after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against the Motion Picture Industry Health Plan or the Claims Administrator, you must do so within 180 days of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Motion Picture Industry Health Plan or the Claims Administrator.

You cannot bring any legal action against the Motion Picture Industry Health Plan or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against Motion Picture Industry Health Plan or the Claims Administrator you must do so within 180 days of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Motion Picture Industry Health Plan or the Claims Administrator.

SECTION 9

Coordination Of Benefits

BENEFITS WHEN YOU HAVE COVERAGE UNDER MORE THAN ONE PLAN

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

WHEN DOES COORDINATION OF BENEFITS APPLY?

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

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

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

WHAT ARE THE RULES FOR DETERMINING THE ORDER OF BENEFIT PAYMENTS?

Order of Benefit Determination Rules

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

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 Amount. Allowable Amount is defined below.

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

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

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

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

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

Secondary Plan and the other Plan is the Primary Plan.

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

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

– the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

– if both parents have the same birthday, the Plan that Covered the parent longest is the Primary Plan.

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

– 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.

– 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.

– 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.

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

a. the Plan covering the Custodial Parent.

b. the Plan covering the Custodial Parent's spouse.

c. the Plan covering the non-Custodial Parent.

d. the Plan covering the non-Custodial Parent's spouse.

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

► 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.

► 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.

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

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

④ **COBRA or State Continuation Coverage**
If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is Covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal

continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

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

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

HOW ARE BENEFITS PAID WHEN THIS PLAN IS SECONDARY?

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

- the Plan determines the amount it would have paid based on the Allowable Amount.
- if this Plan would have paid the same amount or less than the Primary Plan paid, this Plan pays no Benefits.
- if this Plan would have paid more than the Primary Plan paid, the Plan will pay the difference.

You will be responsible for any applicable Co-Payment, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the Allowable Amount.

HOW IS THE ALLOWABLE AMOUNTS DETERMINED WHEN THIS PLAN IS SECONDARY?

Determining the Allowable Amount If this Plan is Secondary

What is an Allowable Amount? For purposes of COB, an Allowable Amount is a health care expense that meets the definition of a Covered Health Care Services under this Plan.

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

WHAT IS DIFFERENT WHEN YOU QUALIFY FOR MEDICARE?

Determining Which Plan is Primary When You Qualify for Medicare

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

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

Determining the Allowable Amount When this Plan is Secondary to Medicare

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

If the provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the Allowable Amount.

Medicare payments, combined with Plan Benefits, will not exceed 100% of the Allowable Amount.

Medicare Crossover Program

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

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

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

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION?

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

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

DOES THIS PLAN HAVE THE RIGHT OF RECOVERY ?

Overpayment and Underpayment of Benefits

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

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

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

Refund of Overpayments

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

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

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

If the refund is due from you and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for you that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payment in connection with services provided

to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will either:

- equal the amount of the required refund, or
- if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan.

The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 10

Subrogation and Reimbursement

WHAT THIS SECTION INCLUDES:

- How your benefits are impacted if you suffer a sickness or injury caused by a third party.

The Plan has a right to subrogation and reimbursement, as defined below. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

SUBROGATION

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which any third party is considered responsible.

Subrogation – Example

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

REIMBURSEMENT

The right to reimbursement means that if it is alleged that any third party caused or is responsible for a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you receive for that Sickness or Injury. The right of reimbursement shall apply to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

Reimbursement – Example

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the Plan 100% of any Benefits you received to treat your injuries.

THIRD PARTIES

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
- the Plan Sponsor in a workers' compensation case or other matter alleging liability.
- any person or entity who is or may be obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.
- any person or entity that is liable for payment to you on any equitable or legal liability theory.

YOU AGREE AS FOLLOWS:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

  – notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
  – providing any relevant information requested by the Plan.
  – signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
  – responding to requests for information about any accident or injuries.
  – making court appearances.
  – obtaining the Plan's consent or its agents' consent before releasing any party from liability

or payment of medical expenses.

– Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

PLAN'S SUBROGATION AND REIMBURSEMENT RIGHTS

- The Plan has a first priority right to receive payment on any claim against any third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- By participating in and accepting Benefits from the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets to the extent of the amount of Plan Benefits provided on behalf of the Covered Person, (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.

- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are Covered under this Plan, the provisions of this section continue to apply, even after you are no longer Covered.
- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the participant, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

RIGHT OF RECOVERY

The Plan has the right to recover benefits it has paid on you or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the calendar year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- submitting a reminder letter to you or a Covered Dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a Covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 11

Other Important Information

WHAT THIS SECTION INCLUDES:

- Your relationship with Oxford and the Plan Administrator;
- Relationships with Providers;
- Your Relationship with Providers;
- Interpretation of Benefits;
- Information and Records;
- Incentives to Providers;
- Incentives for You
- Rebates and Other Payment; and
- Workers Compensation.

YOUR RELATIONSHIP WITH OXFORD AND THE PLAN ADMINISTRATOR

In order to make choices about your health care coverage and treatment, the Motion Picture Industry Health Plan ("Plan") believes that it is important for you to understand how Oxford interacts with the Plan and how it may affect you. Oxford helps administer the Plan in which you are enrolled. Oxford does not provide medical services or make treatment decisions. This means:

- your Plan Administrator and Oxford do not decide what care you need or will receive. You and your Physician make those decisions;
- Oxford communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Services, which are more fully described in this SPD); and
- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

The Plan Administrator and Oxford may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. The Plan Administrator and Oxford will use individually identifiable information about you as permitted or required by law, including in operations and in research. The Plan Administrator and Oxford will use de-identified data for commercial purposes including research.

RELATIONSHIP WITH PROVIDERS

The relationships between the Plan Administrator, Oxford and In-Network providers are solely contractual relationships between independent contractors. In-Network providers are not the Plan Administrator's agents or employees, nor are they agents or employees of Oxford. The Plan Administrator and any of its employees are not agents or employees of In-Network providers, nor is Oxford and any of its employees agents or employees of In-Network providers.

The Plan Administrator and Oxford do not provide health care services or supplies, nor do they practice medicine. Instead, the Plan and Oxford arrange for health care providers to participate in an In-Network and pay Benefits. In-Network providers are independent practitioners who run their own offices and facilities. Oxford's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not the Plan Administrator's employees nor are they employees of Oxford. The Plan Administrator and Oxford do not have any other relationship with In-Network providers such as principal-agent or joint venture. The Plan Administrator and Oxford are not liable for any act or omission of any provider.

Oxford is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

The Plan is solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- the timely payment of Benefits; and
- notifying you of the termination or modifications to the Plan.

YOUR RELATIONSHIP WITH PROVIDERS

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own Provider;
- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Co-Payments, Coinsurance, any Annual Deductible and any

amount that exceeds the Allowable Amount, when applicable;

- are responsible for paying, directly to your provider, the cost of any non-Covered Service;
- must decide if any Provider treating you is right for you (this includes In-Network providers you choose and Providers to whom you have been referred); and
- must decide with your provider what care you should receive.

INTERPRETATION OF BENEFITS

The Plan Administrator and Oxford have the sole and exclusive discretion to do all of the following:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD, the Schedule of Benefits and any Riders and/or Addendums and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

The Plan Administrator and Oxford may delegate this discretionary authority to other persons or entities including Claims Administrator's affiliates that may provide services in regard to the administration of the Plan. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

In certain circumstances, for purposes of overall cost savings or efficiency, the Plan Administrator may, in its discretion, offer Benefits for services that would otherwise not be Covered Services. The fact that the Plan Administrator does so in any particular case shall not in any way be deemed to require the Plan Administrator to do so in other similar cases.

INFORMATION AND RECORDS

Your medical records are confidential documents. Motion Picture Industry Health Plan and Oxford may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. Motion Picture Industry Health Plan and Oxford may request additional information from you to decide your claim for Benefits. Motion Picture Industry Health Plan and Oxford will keep this information confidential. Motion Picture Industry Health Plan and Oxford may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish Motion Picture Industry Health Plan and Oxford with all information or copies of records relating to the services provided to you. Motion Picture Industry Health Plan and Oxford have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Participant's enrollment form. Motion Picture Industry Health Plan and Oxford agree that such information and records will be considered confidential.

The Plan and Oxford have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as The Plan is required to do by law or regulation. During and after the term of the Plan, The Plan and Oxford and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements The Plan recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from Oxford, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, The Plan and Oxford will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Oxford's designees have the same rights to this information as does the Plan Administrator.

INCENTIVES TO PROVIDERS

Network providers may be provided financial incentives by the Claims Administrator to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for In-Network providers are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- a practice called capitation which is when a group of In-Network providers receives a monthly payment from the Claims Administrator for each Covered Person who selects an In-Network Provider within the group to perform or coordinate certain health services. The In-Network Providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.
- bundled payments - certain In-Network Providers receive a bundled payment for a group of Covered Health Care Services for a particular procedure or medical condition. The applicable Co-Payment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The In-Network Providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Co-Payment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Care Services that are not considered part of the inclusive bundled payment and those Covered Health Care Services would be subject to the applicable Co-Payment and/or Coinsurance as described in your *Schedule of Benefits*.

The Claims Administrator uses various payment methods to pay specific In-Network providers. From time to time, the payment method may change.

If you have questions about whether your In-Network provider's contract with the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the telephone number on your ID card. The Claims Administrator can advise whether your In-Network Provider is paid by any financial incentive, including those listed above.

INCENTIVES TO YOU

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but Motion Picture Industry Health Plan recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

REBATES AND OTHER PAYMENTS

Motion Picture Industry Health Plan and the Claims Administrator may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. The rebates are used to offset the cost of paying benefits and administering the Plan.

WORKERS' COMPENSATION

Injuries and diseases Covered under any Workers' Compensation program are excluded from coverage under this Plan.

FUTURE OF THE PLAN

Although Motion Picture Industry Health Plan expects to continue the Plan indefinitely, the Board of Directors of the Plan reserve the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Board of Directors' decision to terminate or amend the Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or Employee Retirement Income Security Act of 1974 (ERISA), or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Board of Directors of the Motion Picture Industry Health Plan does change or terminate the plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final

benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Board of Directors decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be used as may be required by any applicable law.

PLAN DOCUMENT

This Summary Plan Description (SPD) represents an overview of your Benefits. In the event there is a discrepancy between the Supplemental SPD and the Trust Agreement for the Plan, the Trust Agreement will govern. A copy of the Trust Agreement is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of this document by written request to the Plan Administrator, for a nominal charge.

SECTION 12

Glossary

WHAT THIS SECTION INCLUDES:

- Definitions of terms used throughout this Supplement.

Many of the terms used throughout the Supplemental SPD may be unfamiliar to you or have a specific meaning.

Acute – The sudden onset of disease or injury, or a sudden change in the Participant's condition that would require prompt medical attention.

Addendum – Any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of the Supplemental SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the Supplemental SPD, the Addendum shall be controlling.

Air Ambulance – Medical transport by rotary wing Air Ambulance or fixed wing Air Ambulance helicopter or airplane as defined in *42 CFR 414.605*.

Allowable Amounts (or Allowed Amounts) – For Covered Health Care Services, incurred while the Plan is in effect, Allowable Amounts are determined by the Claims Administrator or as required by law as shown in the *Schedule of Benefits*.

Allowable Amounts are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law. The Claims Administrator develops these guidelines, in its discretion, after review of all provider billings in accordance with one or more of the following methodologies:

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

Ambulatory Surgical Centers - A facility currently licensed by the appropriate state regulatory agency for the provisions of surgical and related medical services on an outpatient basis.

Amendment – Any attached written description of additional or alternative provisions to the Plan. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Ancillary Services – Items and services provided by Out-of-Network Physicians at an In-Network facility that are any of the following:

- related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- provided by assistant surgeons, hospitalists, and intensivists;
- diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of Ancillary Services as determined by the Secretary;
- provided by such other specialty practitioners as determined by the Secretary; and
- provided by an Out-of-Network Physician when no other In-Network Physician is available.

Annual Deductible (or Deductible) – The amount you must pay for Covered Services in a calendar year before the Plan will begin paying Out-of-Network Benefits in that calendar year.

Autism Spectrum Disorders – The pervasive developmental disorders set forth in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, including but not limited to Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified.

Behavioral Therapy – Any interactive behavioral therapies derived from evidence-based research, including, but not limited to, Applied Behavior Analysis, cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with ASD that are:

- provided to children less than fifteen years of age; and

- provided or supervised by a behavior analyst who is certified by the Behavior Analyst Certification Board, a licensed physician or a licensed psychologist.

Behavior Therapy is considered to be supervised by a behavior analyst, licensed physician or licensed psychologist when the supervision entails at least one hour of face-to-facer supervision of the autism services provided for each ten hours of Behavioral Therapy.

Benefits – Plan payments for Covered Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Cellular Therapy – Administration of living whole cells into a patient for the treatment of disease.

Claims Administrator – Oxford and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial – A scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA – See Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance – The charge, stated as a percentage of Allowable Amount or the Recognized Amount when applicable, that you are required to pay for certain Covered Health Care Services as described in Section 3, *How the Plan Works*.

Congenital Anomaly – A physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – A federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Co-Payment (or Copayment) – The charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Care Services as described in Section 3, *How the Plan Works*.

Note

For Covered Health Care Services, you are responsible for paying the lesser of the following:

- the applicable Co-Payment.
- the Allowable Amount, or the Recognized Amount when applicable.

Cosmetic Procedures – Procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function like breathing.

Covered or Covered Services – The Medically Necessary services paid for or arranged for you by Oxford under the terms and conditions of the Supplemental SPD.

Covered Person – Either the Participant or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout the Supplemental SPD are references to a Covered Person.

Custodial Care – Services that do not require special skills or training and that:

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible – The amount you owe before the Plan begins to pay for Covered Services. The Deductible applies before any Co-Payments or Coinsurance are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that you owe before the Plan begins to pay for a particular Covered Service.

Dependent – an individual who meets the eligibility requirements as described in the Eligibility Section of this SPD.

Designated Virtual In-Network Provider (or Designated Virtual Network Provider) – a provider

or facility that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to deliver Covered Health Care Services through live audio with video technology or audio only.

Durable Medical Equipment (DME) – Medical equipment that is all of the following:

- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not disposable;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

Emergency – A serious medical condition or symptom resulting from Injury, Sickness or mental illness, or substance-related and addictive disorders which:

- arises suddenly; and
- in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services – With respect to an Emergency:

- an appropriate medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3))*.
- Emergency Health Services include items and services otherwise Covered under the Plan when provided by an Out-of-Network provider or facility (regardless of the department of the Hospital in which the items are services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original Emergency unless the following conditions are met:
  - The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available In-Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.
  - The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
  - The patient is in such a condition, as determined by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law.
  - The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
  - Any other conditions as specified by the Secretary.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

Employee Retirement Income Security Act of 1974 (ERISA) – The federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

EOB – See Explanation of Benefits (EOB).

ERISA – See Employee Retirement Income Security Act of 1974 (ERISA).

Exclusions – What the Plan does not Cover as a Covered Service.

Experimental or Investigational Services – Medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator of the Motion Picture Industry Health Plan makes a determination regarding coverage in a particular case, are determined to be any of the following:

- not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not as appropriate for the proposed use in any of the following:
  - *AHFS Drug Information (AHFS DI)* under therapeutic uses section;
  - *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;
  - *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; or
  - *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.
- subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.)
- the subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.
- only obtainable, with regard to outcomes for the given indication, within research settings.

Exceptions

- Clinical Trials for which Benefits are available as described under Clinical Trials in Section 5: Covered Services.
- The Claims Administrator of the Motion Picture Industry Health Plan may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if:
  - if you are not a participant in a qualifying Clinical Trial as described under Section 5: *Covered Services*; and
  - you have a Sickness or condition that is likely to cause death within one year of the request for treatment

Prior to such consideration, the Claims Administrator of the Motion Picture Industry Health Plan must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) – A statement provided by Oxford to you, your Physician, or another health care professional that explains:

- the benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not Covered by the Plan.

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

Gene Therapy – Therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

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

Habilitation Services – Health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive or behavioral function. These services consist of physical therapy, occupational therapy and speech therapy.

Health Care Professional – An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; or any other licensed, registered or certified Health Care Professional under applicable law that requires to be recognized who charges and bills patients for

Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be Covered under this Plan.

Home Health Agency – A program or organization authorized by law to provide health care services in the home.

Hospice Care – Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified under applicable law required by the state in which the hospice organization is located.

Hospital – A short term, acute, general hospital, which:

- is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- has organized departments of medicine and major surgery;
- has a requirement that every patient must be under the care of a Physician or dentist;
- provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- is duly licensed by the agency responsible for licensing such Hospitals; and
- is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization – Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

Independent Freestanding Emergency Department – A health care facility that:

- is geographically separate and distinct and licensed separately from a Hospital under applicable law; and
- provides Emergency Health Services.

In-Network (or Network) – When used to describe a provider of health care services, this means a Provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network.

In-Network Co-Payment (or Network Copayment) – A fixed amount you pay directly to a Participating Provider for a Covered Service when you receive the Covered Service. The amount can vary by the type of Covered Service.

In-Network Provider (or Network Provider) – A Physician, Certified Nurse Midwife, Hospital, Skilled Nursing Facility, Home Health Care Agency, or any other duly licensed or certified institution or health professional under contract with Oxford to provide Covered Services to our Participants. A list of In-Network Providers and their locations is available to you upon enrollment or upon request. This list will be revised from time to time by Oxford.

Injury – Bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility – A long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay – An uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) – Outpatient Mental Health Care Services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. The most common IBT is *Applied Behavior Analysis (ABA)*.

Intensive Outpatient Treatment – A structured outpatient treatment program.

- for Mental Health Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- for Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health.

Intermediate Care – Mental Health or Substance-Related and

Addictive Disorder treatment that encompasses the following:

- care at a Residential Treatment Facility.
- care at a Partial Hospitalization/ Day Treatment program.
- care through an Intensive Outpatient Treatment program.

Medicaid – A federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary – Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, mental illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by Oxford or its designee, within Oxford's sole discretion. The services must be:

- in accordance with *Generally Accepted Standards of Medical Practice;*
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, mental illness, substance-related and addictive disorder disease or its symptoms;
- not mainly for your convenience or that of your doctor or other health care provider; and
- not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. Oxford reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within Oxford's sole discretion.

Oxford develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by Oxford and revised from time to time), are available to Covered Persons on www.oxhp.com or by calling the number on your ID card.

Medicare – Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services – Covered Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Service.

Mental Health/Substance-Related and Addictive Disorders Designee – The organization or individual, designated by us, that provides or arranges Mental Health Care Services and Substance-Related and Addictive Disorders Services.

Mental Illness – Those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under this Supplement.

Non-Participating Provider – A Provider who doesn't have a contract with the Claims Administrator to provide services to you. You will pay more to see an Out-of-Network Provider.

Out-of-Network Coinsurance (or Non-Network Coinsurance) – Your share of the costs of a Covered Service, calculated as a percent of the Allowable Amount for the Covered Service that you are required to pay to an Out-of-Network Provider.

Out-of-Network Co-Payment (or Non-Network Copayment) – A fixed amount you pay directly to an Out-of-Network Provider for a Covered Service when you receive the Covered Service. The amount can vary by the type of Covered Service.

Out-of-Network Deductible (or Non-Network Deductible) – The amount you owe before the Plan begins to pay for Covered Services received from Out-of-Network Providers. The Out-of-Network Annual Deductible applies before any Coinsurance or Co-Payments are applied. The Out-of-Network Annual Deductible may not apply to all Covered Services. You may also have an Out-of-Network Annual Deductible that applies to a specific Covered Service (for example, a Prescription Drug Deductible) that you owe before the Plan begins to pay for a particular Covered Service.

Out-of-Network Out-of-Pocket Maximum (or Non-Network Out-of-Pocket Limit) – The most you pay in Cost-Sharing before the Plan begins to pay 100% of the Allowable Amount for Covered Services received from Out-of-Network Providers. This maximum never includes your premium, Balance Billing charges or services the Plan does not Cover. You are also responsible for all differences, if any, between the Allowable Amount and the Out-of-Network Provider's charge for Out-of-Network services regardless of whether the Out-of-Pocket Annual Maximum has been met.

Out-of-Pocket Maximum (or Out-of-Pocket Limit) – The maximum amount you pay in Cost-Sharing before the Plan begins to pay 100% of the Allowable Amount for Covered Services. This limit never includes your premium, Balance Billing charges or the cost of health care services the Plan does not Cover. Refer to the *Oxford Highlights* for the Out-of-Pocket Maximum amount.

Partial Hospitalization/Day Treatment – A structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Participant – An active or retired Employee or COBRA Participant who has met the eligibility requirements for participation in the Plan and is eligible to receive Plan benefits.

Pharmaceutical Product(s) – *U.S. Food and Drug Administration (FDA)*- products administered in connection with a Covered Health Care Service by a Physician.

Physician or Physician Services – Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan – The Motion Picture Industry Health Plan.

Plan Administrator – Board of Directors of the Motion Picture Industry Health Plan.

Plan Sponsor – Board of Directors of the Motion Picture Industry Health Plan.

Preauthorization (or Prior Authorization) – Enables Oxford to review the Medical Necessity of a proposed service or treatment including the determination of a proposed site of care, manage benefit limitations, and whether the service will be performed by an In-Network Provider. Preauthorization allows Oxford to notify the Participant or the Participant's Provider regarding coverage before the service is provided.

Prescription Drug – A medication, product or device that has been approved by the Food and Drug Administration ("FDA") and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill and is on Our Formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self administration or administration by a non-skilled caregiver.

Primary Care Physician ("PCP") – A participating Physician who typically is an internal medicine, family practice or pediatric Physician and who directly provides or coordinates a range of health care services for you.

Provider – A Physician, Health Care Professional or Facility licensed, registered, certified or accredited as required by state law. A provider also includes a vendor or dispenser of diabetic equipment and supplies, durable medical equipment, medical supplies, or any other equipment or supplies that are Covered under the Supplemental SPD that is licensed, registered, certified or accredited as required by state law.

Recognized Amount – The amount which Co-Payment, Coinsurance and applicable deductible, is based on for the below Covered Health Services when provided by Out-of-Network providers:

- Out-of-Network Emergency Health Services.
- Non-Emergency Covered Health Services received at certain In-Network facilities by Out-of-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Service Act*. For

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

The amount is based on either:

1. An All Payer Model Agreement if adopted,
2. State law, or
3. The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by an Out-of-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note

Covered Health Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Services were determined based upon an Allowable Amount.

Rehabilitation Services – Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

Remote Physiologic Monitoring – The automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified health care professional to develop and manage a treatment plan related to a chronic and/or acute health illness or condition. The treatment plan will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote Physiologic Monitoring must be ordered by a licensed Physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.

Residential Treatment – Treatment in a facility established and operated as required by law, which provides Mental Health Care Services or Substance-Related and Addictive Disorders Services. It must meet all of the following requirements:

- provides a program of treatment, approved by the Mental Health/Substance-Related and Addictive Disorders Designee, under the active participation and direction of a Physician and, approved by the Mental Health/Substance-Related and Addictive Disorder Designee.
- offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services:
  - room and board.
  - evaluation and diagnosis.
  - counseling.
  - referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Schedule of Benefits – The section of the Supplemental SPD that describes the Co-Payments, Deductibles, Coinsurance, Out-of-Pocket Maximum, Preauthorization requirements and other limits on Covered Services.

Secretary – As that term is applied in the *No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260)*.

Semi-private Room – A room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Services – The Medically Necessary services paid for or arranged for you by Oxford under the terms and conditions of the Supplemental SPD.

Service Area – The geographical area, designated by Oxford and approved by the State of New York in which Oxford provides coverage. Oxford's Service Area consists of the following counties: Bronx, Duchess, Kings, Nassau, New York, Orange, Putnam, Queens,

Richmond, Rockland, Suffolk, Sullivan, Ulster and Westchester.

Shared Savings Program – A program in which the Claims Administrator may obtain a discount to an Out-of-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the Out-of-Network provider and a third party vendor. When this program applies, the Out-of-Network provider's billed charges will be discounted. Plan coinsurance and any applicable deductible would still apply to the reduced charge. Sometimes Plan provisions or administrative practices supersede the scheduled rate, and a different rate is determined by the Claims Administrator.

This means, when contractually permitted, the Plan may pay the lesser of the Shared Savings Program discount or an amount determined by the Claims Administrator, such as:

- a percentage of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market.
- an amount determined based on available data resources of competitive fees in that geographic area.
- a fee schedule established by a third party vendor.
- a negotiated rate with the provider.

In this case the Out-of-Network provider may bill you for the difference between the billed amount and the rate determined by the Claims Administrator. If this happens you should call the number on your ID Card. Shared Savings Program providers are not In-Network providers and are not credentialed by the Claims Administrator.

Skilled Nursing Facility – An institution or a distinct part of an institution that is: currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission , or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; or as otherwise determined by Oxford to meet the standards of any of these authorities.

Specialist – A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Specialty Pharmaceutical Product – Pharmaceutical Products that are generally high cost biotechnology drugs used to treat patients with certain illnesses.

Spouse – The person to whom the Subscriber is legally married, including a same sex Spouse.

Substance-Related and Addictive Disorders Services – Covered Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Service.

Summary Plan Description (SPD) – The Summary Plan Description for the Motion Picture Industry Health Plan for Active Participants or the Summary Plan Description for the Motion Picture Industry Health Plan for Retired Participants including this Supplemental SPD administered by Oxford Health Plan, including the summary of coverage under Oxford Highlights and any attached Amendments.

Surrogate – A female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg the surrogate is biologically (genetically) related to the child.

Telehealth/Telemedicine – Live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual In-Network Provider.

Transitional Care – Mental Health Services and Substance-Related and Addictive Disorders Service that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in *American Society of Addiction Medicine (ASAM)* criteria, that are either:

- sober living arrangements such

as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment does not offer the intensity and structure needed to assist the Member with recovery.

- supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment does not offer the intensity and structure needed to assist the Member with recovery.

Unproven Services – Health services, including medications and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (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.)

Oxford has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, Oxford issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.oxhp.com.

Note

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), Oxford and Motion Picture Industry Health Plan may, at their discretion, consider an otherwise Unproven Service to be a Covered Service for that Sickness or condition. Prior to such a consideration, Oxford and Motion Picture Industry Health Plan must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Service is solely at Oxford's and Motion Picture Industry Health Plan's discretion. Other apparently similar promising but Unproven Services may not qualify.

Urgent Care – A Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in a participating Physician's office or Urgent Care Center.

Urgent Care Center – A licensed facility (other than a Hospital) that provides Urgent Care.

Usual, Customary and Reasonable (UCR) – The cost of a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Utilization Review – The review to determine whether services are or were Medically Necessary or experimental or investigational (including treatment for a rare disease or a clinical trial).

SECTION 13

Important Administrative Information: ERISA

CLAIMS ADMINISTRATOR

Oxford is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the Motion Picture Industry Health Plan. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Administrator's Plan.

The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Administrator's Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

Oxford Health Plans, LLC
P.O. Box 30432
Salt Lake City, Utah 84130-0432

ATTACHMENT I

Gym Reimbursement

COVERAGE FOR EXERCISE FACILITY REIMBURSEMENT

❶ General

The Plan will partially reimburse you for certain exercise facility fees or membership fees but only if such fees are paid to exercise facilities and which maintain equipment and programs that promote cardiovascular wellness.

Memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be reimbursed. Lifetime memberships are not eligible for reimbursement. Reimbursement is limited to actual work-out visits. The Plan will not provide reimbursement for equipment, clothing, vitamins or other services that may be offered by the facility (massages etc.).

In order to be eligible for reimbursement, you must:

- be an active member of the exercise facility.
- complete 50 visits in a six-month period.

In order to obtain reimbursement, at the end of the six-month period you must:

- submit a completed reimbursement form.
- submit a copy of your current facility bill which shows the fee paid for your membership.

Once Oxford receives the completed reimbursement form and the bill, you will be reimbursed as identified on the *Schedule of Benefits* in Section 4, *Plan Highlights*.

❷ Other Terms of Coverage

All other terms, conditions, limitations and exclusions of the Plan remain in full force and effect except as specifically modified by this Attachment.

ATTACHMENT II

Hemophilia Factor Benefits

HEMOPHILIA*

A group of disorders that share the inability to form a proper blood clot. They are characterized by extended bleeding after injury, surgery, trauma or menstruation. Sometimes the bleeding is spontaneous, without a known or identifiable cause. Improper clotting can be caused by defects in blood components such as platelets and/or clotting proteins, also called clotting factors. The body produces 13 clotting factors. If any of them are defective or deficient, blood clotting is affected; a mild, moderate or severe bleeding disorder can result.

The following Covered Services for clotting factor are available only when provided by the specific participating Providers listed below:

1. **Prescription Drug Coverage for clotting factor provided by a Participating Hemophilia Treatment Center**
   The Plan Covers Hemophilia clotting factor that you self-administer or is administered by a non-skilled caregiver when it would otherwise be Covered under your Prescription Drug benefits and it is dispensed by a Participating Hemophilia Treatment Center as part of your written treatment plan. This Covered Service will be provided in lieu of receiving clotting factor dispensed by a Designated Pharmacy under your Prescription Drug Coverage benefit. A "Hemophilia Treatment Center" (HTC) means a unique federally funded entity that specializes in comprehensive care for pediatric and adult individuals with inherited bleeding and clotting disorders. An HTC must be a licensed Facility that is also designated as a comprehensive hemophilia diagnostic treatment center receiving a grant under Section 501(a) (2) of the Social Security Act and participates in the 340B Drug Pricing Program.

   Your Cost-Sharing for clotting factor dispensed by an HTC will be Covered is the Cost-Sharing amount, if any, that applies to intravenous or injectable chemotherapy agents Covered under the Outpatient and Professional Services section of this Supplemental SPD.

2. **Non-Emergent Home Health Care - Assisted Administration of Factor**
   In addition to the Home Health Care Benefits available under Your SPD, the Plan will Cover non-emergent administration of Hemophilia Factor in your home when provided by a Participating Home Health Agency certified or licensed by the appropriate state agency. This additional Home Health Care benefit covers both the clotting factor and the administration services when assisted administration is medically necessary. Coverage will be provided in lieu of receiving medically necessary Covered assisted-administration service from your Physician or another health practitioner in an office or out-patient setting.

   Any visits for assisted administration of Hemophilia clotting factor in Your home count towards Your Home Health Care visit limit. Your cost-sharing and definition of a visit in the Home Health Care Benefits shall apply to these additional services. See your Schedule of Benefits and Home Health Care Covered Service for more information. Please note this benefit only provides Coverage for assisted administration of clotting factor. It does not Cover clotting factor that you self-administer or that is administered by a non-skilled caregiver.

3. **Preauthorization**
   The Covered Services Covered under this Section require Preauthorization. Your Provider must call Oxford or Oxford's vendor at the number indicated on Your ID card.

   After receiving a request for approval, the Plan will review the reasons for Your planned treatment and determine if benefits are available. Criteria will be based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.

4. **Exclusions and limitations**
   Except as expressly modified by this Section, all of the exclusions and limitations of the Supplemental SPD apply to the Covered Services under Covered by this Section.

5 Controlling Contract
All of the terms, conditions, limitations, and exclusions of your Supplemental SPD shall also apply to this Section except where specifically changed by this Section.

*Some bleeding disorders, such as hemophilia, can be inherited or acquired. Others can occur from such conditions as anemia, cirrhosis of the liver, HIV, leukemia and vitamin K deficiency. They also can result from certain medications that thin the blood, including aspirin, heparin and warfarin.

Treatment for bleeding disorders varies, depending on the condition and its severity. For some bleeding disorders, there are clotting factor concentrates that can be infused prophylactically or on-demand at home, to prevent or treat bleeds. For other bleeding disorders, there are topical products, nasal sprays and fresh frozen plasma, which is administered in a hospital setting.

ATTACHMENT III

Nondiscrimination & Accessibility Requirements

When the Plan uses the words "Claims Administrator" in this Attachment, it is a reference to Oxford Health Plans LLC, on behalf of itself and its affiliated companies.

The Claims Administrator on behalf of itself and its affiliated companies complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Oxford does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Claims Administrator provides free aids and services to people with disabilities to communicate effectively with us, such as:

- qualified sign language interpreters
- written information in other formats (large print, audio, accessible electronic formats, other formats)
- free language services to people whose primary language is not English, such as: Qualified interpreters
- information written in other languages

If you need these services, please call the toll-free member number on your health plan ID card, TTY 711 or the Plan Sponsor.

If you believe that the Claims Administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision.

CLAIMS ADMINISTRATOR CIVIL RIGHTS COORDINATOR

Oxford Health Plans LLC
Civil Rights Coordinator
Oxford Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130
The toll-free member phone number listed on your health plan ID card, TTY 711
UHC_Civil_Rights@UHC.com

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

Your can also file a complaint directly with the U.S. Dept. of Health and Human services online, by phone or mail:

Online:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html

Phone:
Toll-free 1-800-368-1019
800-537-7697 (TDD)

Mail:
U.S. Dept. of
Health and Human Services
200 Independence Avenue
SW Room 509F
HHH Building
Washington, D.C. 20201

ATTACHMENT IV

Taglines for Individuals with Limited English Proficiency

You have the right to get help and information in your language at no cost. To request an interpreter, call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711.

This letter is also available in other formats like large print. To request the document in another format, please call the toll-free member phone number listed on your health plan ID card, press 0. TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

Albanian	Ju keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të kërkuar një përkthyes, telefononi në numrin që gjendet në kartën e planit tuaj shëndetësor, shtypni 0. TTY 711.
Amharic	ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። አስተርጓሚ እንዲቀርብልዎ ከፈለጉ በጤና ፕላን መታወቂያዎት ላይ ባለው በተጻ መስመር ስልክ ቁጥር ይደውሉና 0ን ይጫኑ። TTY 711
Arabic	لك الحق في الحصول على المساعدة والمعلومات بلغتك دون تحمل أي تكلفة. لطلب مترجم فوري، اتصل برقم الهاتف المجاني الخاص بالأعضاء المدرج ببطاقة مُعرّف العضوية الخاصة بخطتك الصحية، واضغط على 0. الهاتف النصي (TTY) 711
Armenian	Թարգմանիչ պահանջելու համար, զանգահարե՛ք Ձեր առողջապահական ծրագրի ինքնության (ID) տոմսի վրա նշված անվճար Անդամների հէռախոսահամարով, սեղմե՛ք 0: TTY 711
Bantu-Kirundi	Urafise uburenganzira bwo kuronka ubufasha n'amakuru mu rurimi rwawe ku buntu. Kugira usabe umusemuzi, hamagara inomero ya telephone y'ubuntu yagenewe abanywanyi iri ku rutonde ku karangamuntu k'umugambi wawe w'ubuzima, fyonda 0. TTY 711
Bisayan-Visayan (Cebuano)	Aduna kay katungod nga mangayo og tabang ug impormasyon sa imong lengguwahe nga walay bayad. Aron mohangyo og tighubad, tawag sa toll-free nga numero sa telepono sa miyembro nga nakalista sa imong ID kard sa plano sa panglawas, pindota ang 0. TTY 711

Bengali-Bangala	অনুবাদকের অনুরোধ থাকলে, আপনার স্বাস্থ্য পরিকল্পনার আই ডি কার্ড এ তালিকাভূক্ত ও কর দিতে হবে না এমন টেলিফোন নম্বরে ফোন করুন। (০) শূণ্য চাপুন। TTY 711
Burmese	ကုန်ကျစရိတ်ပေးရန်မလိုဘဲ မိမိဘာသာစကားဖြင့် အကူအညီနှင့် သတင်းအချက်အလက်များ ကိုရယူနိုင်ခြင်း သည်သင်၏အခွင့်အရေးဖြစ်သည်။ စကားပြန်တစ်ဦးတောင်းဆိုရန်သင်၏ကျန်းမာရေးအစီအစဉ် လက်မှတ်ပေါ်ရှိအသင်းဝင်များအတွက်အခမဲ့ဖုန်းလိုင်းသို့ခေါ်ဆိုပြီး 0 ကိုနှိပ်ပါ။ TTY 711
Cambodi-an-Mon-Khmer	អ្នកមានសិទ្ធិទទួលជំនួយ និងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់ថ្លៃ។ ដើម្បីស្នើសុំអ្នកបកប្រែ សូមទូរស័ព្ទទៅលេខឥតចេញថ្លៃសំរាប់សមាជិក ដែលមានកត់នៅក្នុងប័ណ្ណ ID គំរោងសុខភាពរបស់អ្នក រួចហើយចុច 0។ TTY 711
Cherokee	Ꮎ ᎠᏎᏫ ᎰᎵ ᏗᏟᏃᏔᏗ ᏗᏎᏍᏗ ᏥᎪᏪᎳ ᎥᏝ ᏣᏤᎵ ᏙᎯ ᎰᏒ ᏗᎫᎪᏙᏗ ᎪᏟᏍᏙᏗ ᏆᎾᏂᏍᏗᎢ, ᏧᏤᏏᏬᏍᏝ 0. TTY 711
Chinese	您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥打您健保計劃會員卡上的免付費會員電話號碼，再按 0。聽力語言殘障服務專線 711
Choctaw	Chim anumpa ya, apela micha nana aiimma yvt nan aivlli keyu ho ish isha hinla kvt chim aiivlhpesa. Tosholi ya asilhha chi hokmvt chi achukmaka holisso kallo iskitini ya tvli aianumpuli holhtena ya ibai achvffa yvt peh pila ho ish i paya cha 0 ombetipa. TTY 711
Cushite-Oromo	Kaffaltii male afaan keessaniin odeeffannoofi deeggarsa argachuuf mirga ni qabdu. Turjumaana gaafachuufis sarara bilbilaa kan bilisaa waraqaa eenyummaa karoora fayyaa keerratti tarreefame bilbiluun, 0 tuqi. TTY 711
Dutch	U heeft het recht om hulp en informatie in uw taal te krijgen zonder kosten. Om een tolk aan te vragen, bel ons gratis nummer die u op uw ziekteverzekeringskaart treft, druk op 0. TTY 711

French	Vous avez le droit d'obtenir gratuitement de l'aide et des renseignements dans votre langue. Pour demander à parler à un interprète, appelez le numéro de téléphone sans frais figurant sur votre carte d'affilié du régime de soins de santé et appuyez sur la touche 0. ATS 711.
French Creole-Haitian Creole	Ou gen dwa pou jwenn èd ak enfòmasyon nan lang natifnatal ou gratis. Pou mande yon entèprèt, rele nimewo gratis manm lan ki endike sou kat ID plan sante ou, peze 0. TTY 711
German	Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um einen Dolmetscher anzufordern, rufen Sie die gebührenfreie Nummer auf Ihrer Krankenversicherungskarte an und drücken Sie die 0. TTY 711
Greek	Έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να ζητήσετε διερμηνέα, καλέστε το δωρεάν αριθμό τηλεφώνου που βρίσκεται στην κάρτα μέλους ασφάλισης, πατήστε 0. TTY 711
Gujarati	તમને વિના મૂલ્યે મદદ અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા માટે વિનંતી કરવા, તમારા હેલ્થ પ્લાન ID કાર્ડ પરની સૂચીમાં આપેલ ટોલ-ફ્રી મેમ્બર ફોન નંબર ઉપર કોલ કરો, 0 દબાવો. TTY 711
Hawaiian	He pono ke kōkua ʻana aku iā ʻoe ma ka maopopo ʻana o kēia ʻike ma loko o kāu ʻōlelo ponoʻī me ka uku ʻole ʻana. E kamaʻilio ʻoe me kekahi kanaka unuhi, e kāhea i ka helu kelepona kāki ʻole ma kou kāleka olakino, a e kaomi i ka helu 0. TTY 711.
Hindi	आप के पास अपनी भाषा में सहायता एवं जानकारी नि:शुल्क प्राप्त करने का अधिकार है। दुभाषिए के लिए अनुरोध करने के लिए, अपने हैल्थ प्लान ID कार्ड पर सूचीबद्ध टोल-फ्री नंबर पर फ़ोन करें, 0 दबाएं। TTY 711
Hmong	Koj muaj cai tau kev pab thiab tau cov ntaub ntawv sau ua koj hom lus pub dawb. Yog xav tau ib tug neeg txhais, hu tus xov tooj rau tswv cuab hu dawb uas sau muaj nyob ntawm koj daim yuaj them nqi kho mob, nias 0. TTY 711.

Ibo	Inwere ikike inweta enyemaka nakwa ịmụta asụsụ gị n'efu n'akwughị ụgwọ. Maka ịkpọtụrụ onye nsụgharị okwu, kpọọ akara ekwentị nke dị nákwụkwọ njirimara gị nke emere maka ahụike gị, pịa 0. TTY 711.
Ilocano	Adda karbengam nga makaala ti tulong ken impormasyon iti pagsasaom nga libre. Tapno agdawat iti maysa nga agipatarus, tumawag iti toll-free nga numero ti telepono nga para kadagiti kameng nga nakalista ayan ti ID card mo para ti plano ti salunat, ipindut ti 0. TTY 711
Indonesian	Anda berhak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa dikenakan biaya. Untuk meminta bantuan penerjemah, hubungi nomor telepon anggota, bebas pulsa, yang tercantum pada kartu ID rencana kesehatan Anda, tekan 0. TTY 711
Italian	Hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per richiedere un interprete, chiama il numero telefonico verde indicato sulla tua tessera identificativa del piano sanitario e premi lo 0. Dispositivi per non udenti/TTY: 711
Japanese	ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳をご希望の場合は、医療プランのID カードに記載されているメンバー用のフリーダイヤルまでお電話の上、0を押してください。TTY専用番号は 711です。
Karen	နအိာ်ဉီးတါခွဲးတါယာ်လၢနကဉီးန့ါဘဉ်တါမၤစၢၤဒီးးတါဂ့ၢ်တါကျိၤလၢနကျိာ်းဒဉ်နဲဝဲလၢတလိဉ်ဟုဉ်အပူၤဘဉ်နှဉ်လီၤ.လၢတါကဃုဉ်နှ်ပူၤကတိၤကျိုးထံတါတဂၤအဂီၢ်ကီးဘဉ်လီတဲစီအကျိၤလၢကရၢဖိုအတလိဉ်ဟုဉ်အပူၤလၢအအိဉ်လၢနတါအိဉ်ဆူဉ်အိဉ်ချုအတါရဲဉ်တါကျိၤအကးအလိၤဒီးးဆီဉ်လီၤနီၢ်ဂ်ၢ် 0 တကှ်.TTY 711
Korean	귀하는 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 통역사를 요청하기 위해서는 귀하의 플랜 ID카드에 기재된 무료 회원 전화번호로 전화하여 0번을 누르십시오. TTY 711
Kru- Bassa	Ni gwe kunde I bat mahola ni mawin u hop nan nipehmes be to dolla. Yu kwel ni Kobol mahop seblana, soho ni sebel numba I ni tehe mu I ticket I docta I nan, bep 0. TTY 711

Kurdish-Sorani	مافەی ئەوەت هەیە کە بێبەرامبەر، یارمەتی و زانیاری پێویست بە زمانی خۆت وەرگریت. بۆ داواکردنی وەرگێڕێکی زارەکی، پەیوەندی بکە بە ژمارە تەلەفۆنی نووسراو لەناو ئای دی کارتی پیناسەیی پلانی تەندروستی خۆت و پاشان 0 داگرە TTY 711.
Laotian	ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຂໍຮ້ອງນາຍພາສາ,ໂທຜ່ານໝາຍເລກໂທລະສັບສຳລັບ ສະມາຊິກທີ່ໄດ້ລະບຸໄວ້ໃນບັດສະມາຊິກຂອງທ່ານ,ກົດເລກ 0. TTY 711
Marathi	आपल्याला आपल्या भाषेत विनामूल्य मदत आणि माहिती मिळण्याचा अधिकार आहे. दूभाषकास विनंती करण्यासाठी आपल्या आरोग्य योजना ओळखपत्रावरील सूचीबध्द केलेल्या सदस्यास विनामूल्य फोन नंबरवर संपर्क करण्यासाठी दाबा 0. TTY 711
Marshallese	Eor aṃ maroñ ñan bok jipañ im meḷeḷe ilo kajin eo aṃ ilo ejjeḷọk wōṇāān. Ñan kajjitōk ñan juon ri-ukok, kūrḷok nōṃba eo eṃōj an jeje ilo kaat in ID in karōk in ājmour eo aṃ, jiped 0. TTY 711
Micronesian-Pohnpeian	Komw ahneki manaman unsek komwi en alehdi sawas oh mengihtik ni pein omwi tungoal lokaia ni soh isepe. Pwen peki sawas en soun kawehweh, eker delepwohn nempe ong towehkan me soh isepe me ntingihdi ni pein omwi doaropwe me pid koasoandi en kehl, padik 0. TTY 711.
Navajo	T’áá jíík’eh doo bą́ąh ‘alínígóó bee baa hane’ígíí t’áá ni nizaád bee niká’e’eyeego bee ná’ahoot’i’. ‘Ata’ halne’í ła yíníkeedgo, ninaaltsoos nit‘iz7 ‘ats’77s bee baa’ahay1 bee n44hozin7g77 bik11’ b44sh bee hane’7 t’11 j77k’eh bee hane’7 bik1’7g77 bich’8’ hodíilnih dóó 0 bił ‘adidíílchił. TTY 711
Nepali	तपाईंले आफ्नो भाषामा निःशुल्क सहयोग र जानकारी प्राप्त गर्ने अधिकार तपाईसँग छ। अनुवादक प्राप्त गरीपाऊँ भनी अनुरोध गर्न, तपाईंको स्वास्थ्य योजना परिचय कार्डमा सूचीकृत टोल-फ्री सदस्य फोन नम्बरमा सम्पर्क गर्नुहोस्, 0 थिच्नुहोस्। TTY 711
Nilotic-Dinka	Yin nɔŋ löŋ bë yi kuɔny në wërëyic de thöŋ du äbac ke cin wëu tääue ke piny. Äcän bä ran yë kɔc ger thok thiëëc, ke yin cɔl nämba yene yup abac de ran töŋ ye kɔc wäär thok tɔ në ID kat duön de pänakim yic, thäny 0 yic. TTY 711.

Norwegian	Du har rett til å få gratis hjelp og informasjon på ditt eget språk. For å be om en tolk, ring gratisnummeret for medlemmer som er oppført på helsekortet ditt og trykk 0. TTY 711
Pennsylvanian Dutch	Du hoscht die Recht fer Hilf unn Information in deine Schprooch griege, fer nix. Wann du en Iwwersetzer hawwe willscht, kannscht du die frei Telefon Nummer uff dei Gesundheit Blann ID Kaarde yuuse, dricke 0. TTY 711
Persian-Farsi	شما حق دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. برای درخواست مترجم شفاهی با شماره تلفن رایگان قید شده در کارت شناسایی برنامه بهداشتی خود تماس حاصل نموده و 0 را فشار دهید. TTY 711
Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਅਤੇ ਜਾਣਕਾਰੀ ਮੁਫ਼ਤ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ| ਦੁਭਾਸ਼ੀਏ ਲਈ ਤੁਹਾਡੇ ਹੈਲਥ ਪਲਾਨ ਆਈਡੀ ਦਿੱਤੇ ਗਏ ਟਾੱਲ ਫ਼ ਰੀ ਮੈਂਬਰ ਫ਼ੋਨ ਨੰਬਰ ਟੀਟੀਵਾਈ 711 ਤੇ ਕਾੱਲ ਕਰੋ, 0 ਦੱਬੋ|
Polish	Masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Po usługi tłumacza zadzwoń pod bezpłatny numer umieszczony na karcie identyfikacyjnej planu medycznego i wciśnij 0. TTY 711
Portuguese	Você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para solicitar um intérprete, ligue para o número de telefone gratuito que consta no cartão de ID do seu plano de saúde, pressione 0. TTY 711
Romanian	Aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a cere un interpret, sunați la numărul de telefon gratuit care se găsește pe cardul dumneavoastră de sănătate, apăsați pe tasta 0. TTY 711
Russian	Вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы подать запрос переводчика позвоните по бесплатному номеру телефона, указанному на обратной стороне вашей идентификационной карты и нажмите 0. Линия TTY 711

Samoan-Fa'asamoa	E iai lou āiā tatau e maua atu ai se fesoasoani ma fa'amatalaga i lau gagana e aunoa ma se totogi. Ina ia fa'atalosagaina se tagata fa'aliliu, vili i le telefoni mo sui e le totogia o loo lisi atu i lau peleni i lau pepa ID mo le soifua maloloina, oomi le 0. TTY 711.
Serbo-Croation	Imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste zatražili prevodioca, nazovite besplatni broj naveden na iskaznici Vašeg zdravstenog osiguranja i pritisnite 0. TTY 711.
Spanish	Tiene derecho a recibir ayuda e información en su idioma sin costo. Para solicitar un intérprete, llame al número de teléfono gratuito para miembros que se encuentra en su tarjeta de identificación del plan de salud y presione 0. TTY 711
Sudanic-Fulfulde	Ɗum hakke maaɗa mballeɗaa kadin keɓaa habaru nder wolde maaɗa naa maa a yoɓii. To a yiɗi pirtoowo, noddu limngal mo telefol caahu limtaaɗo nder kaatiwol ID maaɗa ngol njamu, nyo''u 0. TTY 711.
Swahili	Una haki ya kupata msaada na taarifa kwa lugha yako bila gharama. Kuomba mkalimani, piga nambariya wanachama ya bure iliyoorodheshwa kwenye TAM ya kadi yako ya mpango wa afya, bonyeza 0. TTY 711
Syriac-Assyrian	ܪܫܝܬܝܐ ܪܫܝܟ ܥܡܠܬܐ ܪܫܝܡ ܒܝܬ ܥܠܠܘܬ ܥܡܫ ܠܝܥܬܐ ܟܬ ܒܐ ܕܝ ܒܐ ܟܬ ܒ ܐ ، ܡܐ ܥ ܒ ܟܬ ܥܡܠܬ ܪܫܝ ܐ ܒ ܐ ܟ ܒ ܫ ܪ ، ܥ ܒ ܟ ܠ ܫ ܪ 0 . TTY 711
Tagalog	May karapatan kang makatanggap ng tulong at impormasyon sa iyong wika nang walang bayad. Upang humiling ng tagasalin, tawagan ang toll-free na numero ng telepono na nakalagay sa iyong ID card ng planong pangkalusugan, pindutin ang 0. TTY 711
Telugu	ఎలాంటి ఖర్చు లేకుండా మీ భాషలో సాయంబు మరియు సమాచార పొందడానికి మీకు హక్కు ఉంది. ఒకవేళ దుబాషి కావాలంటే, మీ హెల్త్ ప్లాన్ ఐడి కార్డు మీద జాబితా చేయబడ్డ టోల్ ఫ్రీ నెంబరుకు ఫోన్ చేసి, 0 ప్రెస్ చేస్కో. TTY 711

Thai	คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย หากต้องการขอล่ามแปลภาษา โปรดโทรศัพท์ถึงหมายเลขโทรฟรีที่อยู่บนบัตรประจำตัวสำหรับแผนสุขภาพของคุณ แล้วกด 0 สำหรับผู้ที่มีความบกพร่องทางการได้ยินหรือการพูด โปรดโทรฯถึงหมายเลข 711
Tongan-Fakatonga	‘Oku ke ma’u ‘a e totonu ke ma’u ’a e tokoni mo e ‘u fakamatala ‘i ho’o lea fakafonua ta’etotongi. Ke kole ha tokotaha fakatonulea, ta ki he fika telefoni ta’etotongi ma’ae kau memipa ‘a ee ‘oku lisi ‘I ho’o kaati ID ki ho’o palani ki he mo’uilelei, Lomi’I ‘a e 0. TTY 711
Trukese (Chuukese)	Mi wor omw pwung om kopwe nounou ika amasou noum ekkewe aninis ika toropwen aninis nge epwe awewetiw non kapasen fonuom, ese kamo. Ika ka mwochen tungoren aninisin chiakku, kori ewe member nampa, ese pwan kamo, mi pachanong won an noum health plan katen ID, iwe tiki “0”. Ren TTY, kori 711.
Turkish	Kendi dilinizde ücretsiz olarak yardım ve bilgi alma hakkınız bulunmaktadır. Bir tercüman istemek için sağlık planı kimlik kartınızın üzerinde yer alan ücretsiz telefon numarasını arayınız, sonra 0’a basınız. TTY (yazılı iletişim) için 711
Ukrainian	У Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб подати запит про надання послуг перекладача, зателефонуйте на безкоштовний номер телефону учасника, вказаний на вашій ідентифікаційній карті плану медичного страхування, натисніть 0. TTY 711
Urdu	آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لئے، ٹول فری ممبر فون نمبر پر کال کریں جو آپ کے ہیلتھ پلان آئی ڈی کارڈ پر درج ہے، 0 دبائیں۔ TTY 711
Vietnamese	Quý vị có quyền được giúp đỡ và cấp thông tin bằng ngôn ngữ của quý vị miễn phí. Để yêu cầu được thông dịch viên giúp đỡ, vui lòng gọi số điện thoại miễn phí dành cho hội viên được nêu trên thẻ ID chương trình bảo hiểm y tế của quý vị, bấm số 0. TTY 711
Yiddish	איר האט די רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך פריי פון אפצאל. צו פארלאנגען א דאלמעטשער, רופט דעם טאל פרייע מעמבער טעלעפאן נומער וואס שטייט אויף אייער העלט פלאן ID קארטל , דרוקט 0. TTY 711
Yoruba	O ní ẹtọ lati rí iranwọ àti ìfitónilétí gbà ní èdè rẹ láìsanwó. Láti bá òǵbufọ kan sọrọ, pè sórí nọmbà ẹrọ ibánisọrọ láisanwó ibodè ti a tò sóri kádi idánimọ ti ètò ilera rẹ, tẹ ‘0’. TTY 711

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