

Plan Summary of Benefits

EPO Plan

for

City of Dallas

Group Number: 708872

Effective Date: January 1, 2009

Table of Contents

Introduction..... 1
 How to Use this Document.....1
 Your Contribution to the Benefit Costs.....1
 Customer Service and Claims Submittal1

Section 1: What's Covered--Benefits 3
 Accessing Benefits3
 Copayment.....3
 Eligible Expenses.....3
 Notification Requirements4
 Payment Information5
 Annual Deductible.....5
 Out-of-Pocket Maximum5
 Maximum Plan Benefit5
 Benefit Information.....6
 1. Ambulance Services - Emergency only6
 2. Cancer Resource Services.....6
 3. Dental Services - Accident only7
 4. Durable Medical Equipment.....8
 5. Emergency Health Services..... 10
 6. Extreme Vision Benefits 10
 7. Eye Examinations..... 10
 8. Hearing Aids 11

To continue reading, go to right column on this page.

9. Home Health Care..... 11
 10. Hospice Care 13
 11. Hospital - Inpatient Stay 13
 12. Infertility Services 14
 13. Injections received in a Physician's Office..... 14
 14. Maternity Services..... 14
 15. Mental Health and Substance Abuse Services - Outpatient..... 15
 16. Mental Health and Substance Abuse Services - Inpatient and Intermediate..... 16
 17. Nutritional Counseling..... 18
 18. Ostomy Supplies 18
 19. Outpatient Surgery, Diagnostic and Therapeutic Services 19
 20. Physician's Office Services 21
 21. Professional Fees for Surgical and Medical Services 23
 22. Prosthetic Devices 24
 23. Reconstructive Procedures 25
 24. Rehabilitation Services - Outpatient Therapy 26
 25. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services 27
 26. Spinal Treatment..... 28
 27. Transplantation Services..... 28
 28. Urgent Care Center Services 30

Section 2: What's Not Covered--Exclusions ... 32

How The Plan Administrator Uses Headings in this Section 32
 The Plan Administrator Does not Pay Benefits for Exclusions 32
 A. Alternative Treatments 32
 B. Comfort or Convenience 32

To continue reading, go to left column on next page.

| | |
|--|----|
| C. Dental..... | 33 |
| D. Drugs | 33 |
| E. Experimental, Investigational or Unproven Services..... | 33 |
| F. Foot Care..... | 33 |
| G. Medical Supplies and Appliances..... | 34 |
| H. Mental Health/Substance Abuse..... | 34 |
| I. Nutrition..... | 35 |
| J. Physical Appearance | 35 |
| K. Preexisting Conditions..... | 35 |
| L. Providers | 35 |
| M. Reproduction..... | 36 |
| N. Services Provided under Another Plan..... | 36 |
| O. Transplants..... | 36 |
| P. Travel..... | 36 |
| Q. Vision and Hearing | 36 |
| R. All Other Exclusions..... | 36 |

Section 3: Obtaining Benefits 38

| | |
|--------------------------------|----|
| Benefits..... | 38 |
| Emergency Health Services..... | 39 |

Section 4: When Coverage Begins..... 41

| | |
|--|----|
| How to Enroll..... | 41 |
| If You Are Hospitalized When Your Coverage Begins..... | 41 |
| If You Are Eligible for Medicare | 41 |
| Who is Eligible for Coverage..... | 42 |
| Eligible Person | 42 |
| Dependent | 42 |

To continue reading, go to right column on this page.

| | |
|--|----|
| When to Enroll and When Coverage Begins..... | 43 |
| Initial Enrollment Period..... | 43 |
| Open Enrollment Period | 43 |
| New Eligible Persons | 43 |
| Adding New Dependents | 44 |
| Special Enrollment Period..... | 45 |

Section 5: How to File a Claim..... 47

| | |
|---|----|
| If You Receive Covered Health Services from a Network Provider..... | 47 |
| Filing a Claim for Benefits..... | 47 |

Section 6: Questions, Complaints and Appeals..... 50

| | |
|---|----|
| What to Do First..... | 50 |
| How to Appeal a Claim Decision..... | 50 |
| Appeal Process | 51 |
| Appeals Determinations..... | 51 |
| Urgent Appeals that Require Immediate Action..... | 51 |

Section 7: When Coverage Ends 54

| | |
|---|----|
| General Information about When Coverage Ends..... | 54 |
| Events Ending Your Coverage | 55 |
| The Entire Plan Ends..... | 55 |
| You Are No Longer Eligible..... | 55 |
| The Claims Administrator Receives Notice to End Coverage..... | 55 |
| Other Events Ending Your Coverage | 56 |

To continue reading, go to left column on next page.

| | |
|--|----|
| Fraud, Misrepresentation or False Information | 56 |
| Material Violation | 56 |
| Improper Use of ID Card | 56 |
| Failure to Pay..... | 56 |
| Threatening Behavior..... | 56 |
| Coverage for a Handicapped Child..... | 57 |
| Leave of Absence..... | 57 |
| Reinstatement of Coverage Following Inactive Status..... | 58 |
| Survivorship Coverage | 58 |
| Continuation of Coverage | 59 |

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

Introduction

The Plan Administrator is pleased to provide you with this Plan Summary of Benefits (PSB). This PSB describes your Benefits, as well as your rights and responsibilities, under the Plan.

How to Use this Document

The Plan Administrator encourages you to read your PSB and any attached Riders and/or Amendments carefully.

The Plan Administrator especially encourages you to review the Benefit limitations of this PSB by reading (Section 1: What's Covered--Benefits) and (Section 2: What's Not Covered--Exclusions). You should call the Claims Administrator if you have questions about the limits of the coverage available to you.

Many of the sections of the PSB are related to other sections of the document. You may not have all of the information you need by reading just one section. The Plan Administrator also encourages you to keep your PSB and any attachments in a safe place for your future reference.

Please be aware that your Physician does not have a copy of your PSB and is not responsible for knowing or communicating your Benefits.

To continue reading, go to right column on this page.

Your Contribution to the Benefit Costs

The Plan may require the Participant to contribute to the cost of coverage. Contact your benefits representative for information about any part of this cost you may be responsible for paying.

Customer Service and Claims Submittal

Please make note of the following information that contains Claims Administrator department names and telephone numbers.

Customer Service Representative (questions regarding Coverage or procedures): As shown on your ID card.

Prior Notification: As shown on your ID card.

Mental Health/Substance Abuse Services Designee: As shown on your ID card.

Claims Submittal Address:

United HealthCare Insurance Company

Attn: Claims

P.O. Box 30555

Salt Lake City, Utah 84130-0555

Customer Service: 800-736-1364

To continue reading, go to left column on next page.

Requests for Review of Denied Claims and Notice of Complaints:

Name and Address for Submitting Requests:

United HealthCare Insurance Company

P.O. Box 30432

Salt Lake City, Utah 84130-0432

Customer Service: 800-736-1364

To continue reading, go to right column on this page.

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Section 1: What's Covered--Benefits

This section provides you with information about:

- Accessing Benefits.
- Copayments and Eligible Expenses.
- Out-of-Pocket Maximum and Maximum Plan Benefit.
- Covered Health Services. The Plan Administrator pays Benefits for the Covered Health Services described in this section unless they are listed as not covered in (Section 2: What's Not Covered--Exclusions).
- Covered Health Services that require you or your provider to notify the Claims Administrator before you receive them. In general, Network providers are responsible for notifying the Claims Administrator before they provide certain health services to you.

Accessing Benefits

You must see a Network Physician to obtain Benefits. For details, see (Section 3: Obtaining Benefits).

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that

To continue reading, go to right column on this page.

you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

Benefits are available only if all of the following are true:

- Covered Health Services are received while the Plan is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in (Section 7: When Coverage Ends) occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Plan.

Copayment

Copayment is the amount you pay each time you receive certain Covered Health Services. Copayment amounts are listed on the following pages next to the description for each Covered Health Service. Please note that when Copayments are calculated as a percentage (rather than as a set dollar amount) the percentage is based on Eligible Expenses. Copayments with a set dollar amount do not apply to the Out-of-Pocket Maximum.

Eligible Expenses

Eligible Expenses for Covered Health Services, incurred while the Plan is in effect, are determined by us or by our designee. In almost all cases our designee is the Claims Administrator.

The Plan Administrator has delegated to the Claims Administrator the discretion and authority to initially determine on our behalf whether a treatment or supply is a Covered Health Service and how the Eligible Expense will be determined and otherwise covered under the Plan.

To continue reading, go to left column on next page.

When you receive Covered Health Services from Network providers, you are not responsible for any difference between the Eligible Expenses and the amount the provider bills. When you receive Covered Health Services from non-Network providers, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount the Plan Administrator will pay for Eligible Expenses.

Notification Requirements

In general, Network providers are responsible for notifying the Claims Administrator before they provide these services to you. There are some Benefits, however, for which you are responsible for notifying the Claims Administrator.

To continue reading, go to right column on this page.

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Payment Information

| Payment Term | Description | Amounts |
|------------------------------|---|---|
| Annual Deductible | The amount you pay for Covered Health Services before you are eligible to receive Benefits. | No Annual Deductible. |
| Out-of-Pocket Maximum | The maximum you pay, out of your pocket, in a calendar year for Copayments. | \$5,000 per Covered Person per calendar year, not to exceed \$10,000 for all Covered Persons in a family. |
| Maximum Plan Benefit | The maximum amount the Plan Administrator will pay for Benefits during the entire period of time you are enrolled under the Plan. | No Maximum Plan Benefit. |

Benefit Information

| Description of Covered Health Service | Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small> | Does Copayment Help Meet Out-of-Pocket Maximum? |
|---|--|---|
| <p>1. Ambulance Services - Emergency only Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.</p> | <p><i>Ground Transportation:</i> \$100, then 25% per transport</p> <p><i>Air Transportation:</i> \$100, then 25% per transport</p> | Yes |
| <p>2. Cancer Resource Services The Plan Administrator will arrange for access to certain of our Network providers that participate in the Cancer Resource Services program for the provision of oncology services. The Plan Administrator may refer you to Cancer Resource Services, or you may self refer to Cancer Resource Services by calling 866-936-6002. In order to receive the highest level of Benefits, you must contact Cancer Resource Services prior to obtaining Covered Health Services. The oncology services include Covered Health Services and supplies rendered for the treatment of a condition that has a primary or suspected diagnosis relating to cancer.</p> <p>In order to receive Benefits under this program, Cancer Resource Services must provide the proper notification to the Network provider performing the services. This is true even if you self refer to a Network provider participating in the program.</p> | <p>Benefits will be paid the same as Benefits for Hospital-Inpatient Stay, Outpatient Surgery, Diagnostic and Therapeutic Services, Physician's Office Services, and Professional Fees for Surgical and Medical Services</p> | |

| Description of Covered Health Service | Your Copayment Amount % Copayments are based on a percent of Eligible Expenses | Does Copayment Help Meet Out-of-Pocket Maximum? |
|---|---|---|
| <h3>3. Dental Services - Accident only</h3> <p>Dental services when all of the following are true:</p> <ul style="list-style-type: none"> • Treatment is necessary because of accidental damage. • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D." • The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. <p>Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was:</p> <ul style="list-style-type: none"> • A virgin or unrestored tooth, or • A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech. <p>Dental services for final treatment to repair the damage must be both of the following:</p> <ul style="list-style-type: none"> • Started within six months of the accident. • Completed within six months of the accident. <p>Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to</p> | 25% | Yes |

**Description of
Covered Health Service**

**Your Copayment
Amount**

% Copayments are
based on a percent of
Eligible Expenses

**Does
Copayment
Help Meet
Out-of-Pocket
Maximum?**

teeth that are injured as a result of such activities.

Notify the Claims Administrator

Please remember that you must notify the Claims Administrator at the telephone number on your ID card as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. (You do not have to provide notification before the initial Emergency treatment.)

4. Durable Medical Equipment

25%

Yes

Medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use in the home.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment.

Examples of Durable Medical Equipment include:

**Description of
Covered Health Service**

**Your Copayment
Amount**

% Copayments are
based on a percent of
Eligible Expenses

**Does
Copayment
Help Meet
Out-of-Pocket
Maximum?**

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. See **Prosthetic Devices** section regarding orthotic devices. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage). Filters for sleep apnea machines are covered.

The Plan Administrator and the Claims Administrator will decide if the equipment should be purchased or rented. You must purchase or rent the Durable Medical Equipment from the vendor the Claims Administrator identifies.

| Description of Covered Health Service | Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small> | Does Copayment Help Meet Out-of-Pocket Maximum? |
|--|---|---|
| <p>5. Emergency Health Services</p> <p>Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.</p> <p>You will find more information about Benefits for Emergency Health Services in (Section 3: Obtaining Benefits).</p> | <p>\$150 per visit, then 25%</p> <p>Copay waived if admitted to a Hospital within 48 hours of receiving Emergency Health Services</p> | <p>Yes</p> |
| <p>6. Extreme Vision Benefits</p> <p>The following are covered services:</p> <ul style="list-style-type: none"> The evaluation, fitting cost and purchase cost of contact lenses if there is a diagnosis of Karatoconus. <p>Benefits are limited to once every 12 months.</p> | <p>\$45 per visit</p> | <p>No</p> |
| <p>7. Eye Examinations</p> <p>Eye examinations received from a health care provider in the provider's office. .</p> <p>Benefits include one routine vision exam, including refraction, to detect vision impairment by a Network provider each calendar year.</p> <p>Please note that Benefits are not available for charges connected to</p> | <p>\$25 per visit, except that the Copayment for a Network Specialist Physician office visit is \$45</p> <p>\$10 Copay for</p> | <p>Yes</p> |

| Description of Covered Health Service | Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small> | Does Copayment Help Meet Out-of-Pocket Maximum? |
|--|--|---|
| the purchase or fitting of eyeglasses or contact lenses. | eyeglass exam; \$20 Copay for contact lens exam | |
| 8. Hearing Aids Benefits for hearing aids, including evaluation and fitting as follows: <ul style="list-style-type: none"> • One audiometric examination and hearing aid evaluation test to determine actual hearing acuity and the specific type or brand of hearing aid needed. • Purchase and fitting of hearing aid(s), including one hearing aid check following the fitting. Benefits for hearing aids are limited to one device every 36 months, up to \$1,000 per calendar year. | 25% | Yes |
| 9. Home Health Care Services received from a Home Health Agency that are both of the following: <ul style="list-style-type: none"> • Ordered by a Physician. • Provided by or supervised by a registered nurse in your home. Benefits are available only when the Home Health Agency services | \$25 per visit; 25% for private duty nursing | Yes |

**Description of
Covered Health Service**

**Your Copayment
Amount**

% Copayments are
based on a percent of
Eligible Expenses

**Does
Copayment
Help Meet
Out-of-Pocket
Maximum?**

are provided on a part-time, intermittent schedule and when skilled care is required.

Benefits for Home Health Agency services include private duty nursing.

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

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

The Plan Administrator and the Claims Administrator will decide if skilled care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

| Description of Covered Health Service | Your Copayment Amount % Copayments are based on a percent of Eligible Expenses | Does Copayment Help Meet Out-of-Pocket Maximum? |
|--|---|---|
| <p>10. Hospice Care</p> <p>Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed hospice agency.</p> <p>Please contact the Claims Administrator for more information regarding guidelines for hospice care. You can contact the Claims Administrator at the telephone number on your ID card.</p> <p>Benefits are limited to \$20,000 per calendar year.</p> | 25% | Yes |
| <p>11. Hospital - Inpatient Stay</p> <p>Inpatient Stay in a Hospital. Benefits are available for:</p> <ul style="list-style-type: none"> • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). <p>Benefits for Physician services are described under <i>Professional Fees for Surgical and Medical Services</i>.</p> | \$600 per Inpatient Stay then 25% | Yes |

| Description of Covered Health Service | Your Copayment Amount % Copayments are based on a percent of Eligible Expenses | Does Copayment Help Meet Out-of-Pocket Maximum? |
|---|---|---|
| <p>12. Infertility Services Services for the treatment of infertility when provided by or under the direction of a Network Physician.</p> | \$25 per visit; 50% for artificial insemination | Yes |
| <p>13. Injections received in a Physician's Office Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.</p> | 50% per injection | Yes |
| <p>14. Maternity Services Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.</p> <p>There are special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the programs. To sign up, you should notify the Claims Administrator during the first trimester, but no later than one month prior to the anticipated childbirth.</p> <p>The Plan Administrator will pay Benefits for an Inpatient Stay of at least:</p> <ul style="list-style-type: none"> • 48 hours for the mother and newborn child following a normal | Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Surgery, Diagnostic and Therapeutic Services. | No Copayment applies to Physician office visits for prenatal care after the first visit for which a \$25 copay applies. |

| Description of Covered Health Service | Your Copayment Amount % Copayments are based on a percent of Eligible Expenses | Does Copayment Help Meet Out-of-Pocket Maximum? |
|--|---|---|
| <p>vaginal delivery.</p> <ul style="list-style-type: none"> 96 hours for the mother and newborn child following a cesarean section delivery. <p>If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.</p> | | |
| <p>15. Mental Health and Substance Abuse Services - Outpatient</p> <p>Mental Health Services and Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including:</p> <ul style="list-style-type: none"> Mental health, substance abuse and chemical dependency evaluations and assessment. Diagnosis. Treatment planning. Referral services. Medication management. Short-term individual, family and group therapeutic services (including intensive outpatient therapy). Crisis intervention. <p>Referrals to a Mental Health/Substance Abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee,</p> | \$50 per visit | Yes |

| Description of Covered Health Service | Your Copayment Amount % Copayments are based on a percent of Eligible Expenses | Does Copayment Help Meet Out-of-Pocket Maximum? |
|---|---|---|
| <p>who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for outpatient Mental Health and Substance Abuse Services.</p> <p>Benefits for Mental Health Services are limited to 20 visits per calendar year.</p> <p>Benefits for Serious Mental Health Services are limited to 60 visits per calendar year.</p> <p>Benefits for Substance Abuse Services are limited to 3 series per lifetime.</p> <p style="text-align: center;">Authorization Required</p> <p>Please remember that you must call and get authorization to receive these Benefits, in advance of any treatment, through the Mental Health/Substance Abuse Designee. The Mental Health/Substance Abuse Designee phone number appears on your ID card.</p> <p>Without authorization, you will be responsible for paying all charges and no Benefits will be paid.</p> | | |
| <p>16. Mental Health and Substance Abuse Services - Inpatient and Intermediate</p> <p>Mental Health Services and Substance Abuse Services received on an inpatient or intermediate care basis in a Hospital or an Alternate Facility. Benefits include detoxification from abusive chemicals or substances that is limited to physical detoxification when necessary</p> | <p>\$600 per Inpatient Stay, then 25%</p> | <p>Yes</p> |

**Description of
Covered Health Service**

**Your Copayment
Amount**

% Copayments are
based on a percent of
Eligible Expenses

**Does
Copayment
Help Meet
Out-of-Pocket
Maximum?**

to protect your physical health and well-being.

The Mental Health/Substance Abuse Designee, who will arrange for the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. At the discretion of the Mental Health/Substance Abuse Designee, two sessions of intermediate care (such as partial hospitalization) may be substituted for one inpatient day.

Mental Health Services and Substance Abuse Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. Referrals to a Mental Health/Substance Abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for inpatient/intermediate Mental Health Services and Substance Abuse Services.

Benefits for Mental Health Services are limited to 30 days per calendar year.

Benefits for Serious Mental Health Services are limited to 45 days per calendar year.

Benefits for Substance Abuse Services are limited to 3 series per lifetime.

| Description of Covered Health Service | Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small> | Does Copayment Help Meet Out-of-Pocket Maximum? |
|---|--|---|
| Authorization Required | | |
| Please remember that you must call and get authorization to receive these Benefits, in advance of any treatment, through the Mental Health/Substance Abuse Designee. The Mental Health/Substance Abuse Designee phone number appears on your ID card. | | |
| Without authorization, you will be responsible for paying all charges and no Benefits will be paid. | | |
| 17. Nutritional Counseling Covered Health Services provided by a registered dietician in an individual session for Covered Persons with diabetes mellitus. | 25% | Yes |
| 18. Ostomy Supplies Benefits for ostomy supplies include only the following: <ul style="list-style-type: none"> • Pouches, face plates and belts. • Irrigation sleeves, bags and catheters. • Skin barriers. Benefits are not available for gauze, adhesive, adhesive remover, deodorant, pouch covers, or other items not listed above. | 25% | Yes |

| Description of Covered Health Service | Your Copayment Amount % Copayments are based on a percent of Eligible Expenses | Does Copayment Help Meet Out-of-Pocket Maximum? |
|---|---|---|
| 19. Outpatient Surgery, Diagnostic and Therapeutic Services | | |
| <p><i>Outpatient Surgery</i> Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.</p> <p>Benefits under this section include only the facility charge and the charge for supplies and equipment. Benefits for the surgeon fees related to outpatient surgery are described under <i>Professional Fees for Surgical and Medical Services</i> below.</p> <p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> below.</p> | \$300 per surgical procedure, then 25% | Yes |
| <p><i>Outpatient Diagnostic Services</i> Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:</p> <ul style="list-style-type: none"> • Lab and radiology/X-ray. • Mammography testing (One routine mammogram per calendar year for ages 35 and up). <p>Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.</p> | <p><i>For preventive diagnostic services:</i> 25%</p> <p><i>For preventive mammography testing:</i></p> | Yes |

| Description of Covered Health Service | Your Copayment Amount % Copayments are based on a percent of Eligible Expenses | Does Copayment Help Meet Out-of-Pocket Maximum? |
|---|---|---|
| When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> below. | 25% | Yes |
| This section does not include Benefits for CT scans, PET scans, MRIs, or nuclear medicine, which are described immediately below. | <i>For Sickness and Injury-related diagnostic services:</i> 25% | Yes |

| Description of Covered Health Service | Your Copayment Amount % Copayments are based on a percent of Eligible Expenses | Does Copayment Help Meet Out-of-Pocket Maximum? |
|--|---|---|
| <p><i>Outpatient Diagnostic/Therapeutic Services - CT Scans, PET Scans, MRI and Nuclear Medicine</i> Covered Health Services for CT scans, PET scans, MRI, and nuclear medicine received on an outpatient basis at a Hospital or Alternate Facility.</p> <p>Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.</p> | \$100 per test, then 25% | Yes |
| <p><i>Outpatient Therapeutic Treatments</i> Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.</p> <p>Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.</p> <p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> below.</p> | 25% | Yes |
| <p>20. Physician's Office Services Covered Health Services for preventive medical care.</p> <p>Preventive medical care includes:</p> <ul style="list-style-type: none"> • Voluntary family planning. | \$25 per visit, except that the Copayment for a Network | Yes |

| Description of Covered Health Service | Your Copayment Amount | Does Copayment Help Meet Out-of-Pocket Maximum? |
|---|--|---|
| <ul style="list-style-type: none"> Well-baby and well-child care. Routine physical examinations, including Pap smears and associated exams for females age 17 and up; mammograms annually for females age 35 and up; PSA testing annually for males age 35 and up; colonoscopy once every 5 years for males and females age 50 and up. Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment. See <i>Eye Examinations</i> earlier in this section.) Immunizations. | <p style="text-align: center;">% Copayments are based on a percent of Eligible Expenses</p> <p>Specialist Physician office visit is \$45</p> <p>No Copayment applies when no Physician charge is assessed.</p> | |
| <p>Routine exams and screenings are subject to the following limits:</p> | | |
| <ul style="list-style-type: none"> 6 visits per calendar year for ages 0 to 24 months. 1 visit per calendar year for ages 2 and up. Annual Pap Smears for females ages 20 and up. Annual Mammograms for females ages 35 and up. Annual PSA testing for males ages 35 and up. Colonoscopy once every 5 years for males and females ages 50 and up. Annual cholesterol screening for men ages 30 to 65. Annual blood pressure screening for ages 17 and up. Cholesterol screening every 2 years for women ages 40 to 65. Annual obesity screening for ages 17 and up. Cervical cancer screening every 2 years for ages 17 and up. Immunizations - Tetanus and Diphtheria every 10 years for | | |

| Description of Covered Health Service | Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small> | Does Copayment Help Meet Out-of-Pocket Maximum? |
|--|--|---|
| <p>ages 17 and up.</p> <ul style="list-style-type: none"> - Immunizations – Influenza annually for ages 17 and up. - Immunizations – Hepatitis A/B for any person at risk. <p>Follow-up visits do not count as a Preventive Visit.</p> <p>Covered Health Services for the diagnosis and treatment of a Sickness or Injury received in a Physician's office.</p> | <p>\$25 per visit, except that the Copayment for a Network Specialist Physician office visit is \$45</p> <p>No Copayment applies when no Physician charge is assessed.</p> | <p>Yes</p> |
| <p>21. Professional Fees for Surgical and Medical Services</p> <p>Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.</p> | <p>25%</p> | <p>Yes</p> |

| Description of Covered Health Service | Your Copayment Amount % Copayments are based on a percent of Eligible Expenses | Does Copayment Help Meet Out-of-Pocket Maximum? |
|---|---|---|
| When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> above. | | |

22. Prosthetic Devices

External prosthetic devices that replace a limb or an external body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial eyes, ears and noses.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.
- Orthotic devices.

Benefits are also provided for wigs that are required as a result of cancer. Benefits for wigs are limited to a maximum of \$300.

25%

Yes

| Description of Covered Health Service | Your Copayment Amount % Copayments are based on a percent of Eligible Expenses | Does Copayment Help Meet Out-of-Pocket Maximum? |
|--|---|---|
| <p>If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.</p> <p>The prosthetic device must be ordered or provided by, or under the direction of a Physician.</p> <p>Except for wigs and items required by the Women's Health and Cancer Rights Act of 1998, Benefits for prosthetic devices is limited to \$10,000 per calendar year. This limit applies to the total amount that we will pay for the prosthetics, and does not include any Copayment responsibility you may have.</p> <p>Once this Benefit limit is reached, no additional Benefits are available except for wigs and items required by the Women's Health and Cancer Rights Act of 1998.</p> | | |
| <p>23. Reconstructive Procedures</p> <p>Services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function.</p> <p>Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or</p> | <p>Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.</p> | |

| Description of Covered Health Service | Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small> | Does Copayment Help Meet Out-of-Pocket Maximum? |
|--|--|---|
| <p>restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.</p> <p>Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact the Claims Administrator at the telephone number on your ID card for more information about Benefits for mastectomy related services.</p> | \$45 per visit | Yes |
| <p>24. Rehabilitation Services - Outpatient Therapy</p> <p>Short-term outpatient rehabilitation services for:</p> <ul style="list-style-type: none"> • Physical therapy. • Occupational therapy. • Speech therapy. • Pulmonary rehabilitation therapy. • Cardiac rehabilitation therapy. | | |

| Description of Covered Health Service | Your Copayment Amount % Copayments are based on a percent of Eligible Expenses | Does Copayment Help Meet Out-of-Pocket Maximum? |
|---|---|---|
| <p>Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician.</p> <p>Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment.</p> <p>Please note that the Plan Administrator will pay Benefits for speech therapy for a diagnosis of autism for children up to age 3. After that, speech therapy for a diagnosis of autism is not covered.</p> <p>In addition, the Plan Administrator will pay Benefits for speech therapy when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly.</p> | | |
| <p>25. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</p> | \$25 per day. | Yes |
| <p>Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:</p> <ul style="list-style-type: none"> • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). <p>Benefits are limited to 30 days per calendar year.</p> <p>Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise</p> | | |

| Description of Covered Health Service | Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small> | Does Copayment Help Meet Out-of-Pocket Maximum? |
|---|--|---|
| required an Inpatient Stay in a Hospital. | | |
| <p>26. Spinal Treatment</p> <p>Benefits for Spinal Treatment when provided by a Network Spinal Treatment provider in the provider's office.</p> <p>Benefits include diagnosis and related services and are limited to one visit and treatment per day.</p> | \$45 per visit | Yes |
| <p>27. Transplantation Services</p> <p>Covered Health Services for the following organ and tissue transplants when ordered by a Physician. Transplantation services must be received at a Designated Facility. Benefits are available for the transplants listed below when the transplant meets the definition of a Covered Health Service, and is not an Experimental, Investigational or Unproven Service:</p> <ul style="list-style-type: none"> • Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. • Heart transplants. • Heart/lung transplants. • Lung transplants. • Kidney transplants. • Kidney/pancreas transplants. | \$600 per Inpatient Stay, then 25%. | Yes |

**Description of
Covered Health Service**

**Your Copayment
Amount**

% Copayments are
based on a percent of
Eligible Expenses

**Does
Copayment
Help Meet
Out-of-Pocket
Maximum?**

- Liver transplants.
- Liver/small bowel transplants.
- Pancreas transplants.
- Small bowel transplants.

Benefits are also available for cornea transplants that are provided by a Network Physician at a Network Hospital. The Plan Administrator does not require that cornea transplants be performed at a Designated Facility.

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage.

Under the Plan there are specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the telephone number on your ID card for information about these guidelines.

Transportation and Lodging

The Claims Administrator will assist the patient and family with travel and lodging arrangements when services are received from a Designated Facility. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.

| Description of Covered Health Service | Your Copayment Amount % Copayments are based on a percent of Eligible Expenses | Does Copayment Help Meet Out-of-Pocket Maximum? |
|---|---|---|
| <ul style="list-style-type: none"> • Eligible Expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to \$75 for one person or up to \$150 for two people. • Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Designated Facility. • If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the \$150 per diem rate. <p>There is a combined overall lifetime maximum Benefit of \$10,000 per Covered Person for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures.</p> | | |
| <p>28. Urgent Care Center Services Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a</p> | \$45 per visit, then 25% | Yes |

**Description of
Covered Health Service**

**Your Copayment
Amount**

% Copayments are
based on a percent of
Eligible Expenses

**Does
Copayment
Help Meet
Out-of-Pocket
Maximum?**

Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this section.

To ensure prompt and accurate payment of your claim, notify the Claims Administrator within two business days after you receive care at an Urgent Care Center outside the service area.

Section 2: What's Not Covered-- Exclusions

This section contains information about:

- How headings are used in this section.
- Medical services that are not covered. The Plan Administrator call these Exclusions. It's important for you to know what services and supplies are not covered under the Plan.

How The Plan Administrator Uses Headings in this Section

To help you find specific exclusions more easily, the Plan Administrator uses headings. The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

To continue reading, go to right column on this page.

The Plan Administrator Does not Pay Benefits for Exclusions

The Plan Administrator will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following are true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in (Section 1: What's Covered--Benefits) or through a Rider to the PSB.

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aroma therapy.
3. Hypnotism.
4. Massage Therapy.
5. Rolfing.
6. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

B. Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/Barber service.
4. Guest service.

To continue reading, go to left column on next page.

5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
 - Air conditioners.
 - Air purifiers and filters.
 - Batteries and battery chargers.
 - Dehumidifiers.
 - Humidifiers.
6. Devices and computers to assist in communication and speech.

C. Dental

1. Dental care except as described in (Section 1: What's Covered--Benefits) under the heading *Dental Services - Accident only*.
2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
 - Extraction, restoration and replacement of teeth.
 - Medical or surgical treatments of dental conditions.
 - Services to improve dental clinical outcomes.
3. Dental implants.
4. Dental braces.
5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:
 - Transplant preparation.
 - Initiation of immunosuppressives.
 - The direct treatment of acute traumatic Injury, cancer or cleft palate.
6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly.

To continue reading, go to right column on this page.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications.
3. Non-injectable medications given in a Physician's office except as required in an Emergency.
4. Over the counter drugs and treatments.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational and Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

1. Routine foot care (including the cutting or removal of corns and calluses).
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include the following:
 - Cleaning and soaking the feet.
 - Applying skin creams in order to maintain skin tone.
 - Other services that are performed when there is not a localized illness, Injury or symptom involving the foot.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.

To continue reading, go to left column on next page.

G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
 - Elastic stockings.
 - Ace bandages.
 - Gauze and dressings.
 - Syringes.
 - Diabetic test strips.
3. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces).
4. Tubings and masks are not covered except when used with Durable Medical Equipment as described in (Section 1: What's Covered--Benefits).

H. Mental Health/Substance Abuse

1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
2. Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention.
3. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.
4. Treatment for 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

To continue reading, go to right column on this page.

management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.

5. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
6. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee.
7. Residential treatment services.
8. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following:
 - Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
 - Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
 - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
 - Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time.

The Mental Health/Substance Abuse Designee 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.

To continue reading, go to left column on next page.

I. Nutrition

1. Megavitamin and nutrition based therapy.
2. Nutritional counseling for either individuals or groups except as specifically described in (Section 1: What's Covered--Benefits).
3. Internal feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

J. Physical Appearance

1. Cosmetic Procedures. See the definition in (Section 10: Glossary of Defined Terms). Examples include:
 - Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
 - Skin abrasion procedures performed as a treatment for acne.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.
Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in (Section 1: What's Covered--Benefits).
3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
5. Wigs regardless of the reason for the hair loss except for wigs required as a result of cancer.

To continue reading, go to right column on this page.

K. Preexisting Conditions

1. Benefits for the treatment of a Preexisting Condition are excluded until the date you have had Continuous Creditable Coverage for 12 months.
This exclusion does not apply to newborn children or newly adopted children or pregnancy. This exception for newborn and adopted children no longer applies after the end of the first 63-day period during which the child has not had Continuous Creditable Coverage.

L. Providers

1. Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
 - Has not been actively involved in your medical care prior to ordering the service, or
 - Is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography testing.

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M. Reproduction

1. Surrogate parenting.
2. The reversal of voluntary sterilization.
3. Health services and associated expenses for elective abortion.
4. Fetal reduction surgery.
5. Health services associated with the use of non-surgical or drug-induced Pregnancy termination.

N. Services Provided under Another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

O. Transplants

1. Health services for organ and tissue transplants, except those described in (Section 1: What's Covered--Benefits).
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor

To continue reading, go to right column on this page.

costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan).

3. Health services for transplants involving mechanical or animal organs.
4. Transplant services that are not performed at a Designated Facility.
5. Any solid organ transplant that is performed as a treatment for cancer.
6. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Services* in (Section 1: What's Covered--Benefits).

P. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

Q. Vision and Hearing

1. Purchase cost of eye glasses or contact lenses.
2. Fitting charge for eye glasses or contact lenses.
3. Eye exercise therapy.
4. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

R. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service.

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2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
 - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
 - Related to judicial or administrative proceedings or orders.
 - Conducted for purposes of medical research.
 - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
4. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
6. Charges in excess of Eligible Expenses or in excess of any specified limitation.
7. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.
8. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.
9. Non-surgical treatment of obesity, including morbid obesity.
10. Surgical treatment of obesity including severe morbid obesity.
11. Growth hormone therapy.
12. Sex transformation operations.
13. Custodial Care.
14. Domiciliary care.
15. Private duty nursing provided on an inpatient basis.
16. Respite care.
17. Rest cures.
18. Psychosurgery.
19. Treatment of benign gynecomastia (abnormal breast enlargement in males).
20. Medical and surgical treatment of excessive sweating (hyperhidrosis).
21. Panniculectomy, abdominoplasty, thighplasty, brachioplasty, mastopexy, and breast reduction. This exclusion does not apply to breast reconstruction following a mastectomy as described under *Reconstructive Procedures* in (Section 1: What's Covered--Benefits).
22. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
23. Oral appliances for snoring.
24. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, Congenital Anomaly or autism in a child up to age 3.
25. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
26. Any charge for services, supplies or equipment advertised by the provider as free.
27. Any charges prohibited by federal anti-kickback or self-referral statutes.

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Section 3: Obtaining Benefits

This section includes information about:

- Obtaining Benefits.
- Emergency Health Services.

Benefits

Benefits are payable for Covered Health Services which are any of the following:

- Provided by or under the direction of a Network Physician or other Network provider in the Physician's office or at a Network facility.
- Emergency Health Services.
- Urgent Care Center services received outside the service area.

Benefits are not payable for Covered Health Services that are provided by non-Network providers.

Please note that Mental Health and Substance Abuse Services must be authorized by the Mental Health/Substance Abuse Designee. Please see (Section 1: What's Covered--Benefits) under the heading for *Mental Health and Substance Abuse*.

To continue reading, go to right column on this page.

Provider Network

The Claims Administrator arranges for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees or employees of the Claims Administrator. It is your responsibility to select your provider.

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

You will be given a directory of Network providers. However, before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the Claims Administrator.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider.

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

Care CoordinationSM

Your Network Physician is required to notify the Claims Administrator regarding certain proposed or scheduled health services. When your Network Physician notifies the Claims Administrator, they will work together to implement the Care

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CoordinationSM process and to provide you with information about additional services that are available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy.

If you receive certain Covered Health Services from a Network provider, you must notify the Claims Administrator. The Covered Health Services for which notification is required is shown in (Section 1: What's Covered--Benefits). When you notify the Claims Administrator, you will be provided with the Care Coordination services described above.

Designated Facilities and Other Providers

If you have a medical condition that the Claims Administrator believes needs special services, they may direct you to a Designated Facility or other provider chosen by them. If you require certain complex Covered Health Services for which expertise is limited, the Claims Administrator may direct you to a non-Network facility or provider.

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

You or your Network Physician must notify the Claims Administrator of special service needs (including, but not limited to, transplants or cancer treatment) that might warrant referral to a Designated Facility or non-Network facility or provider. If you do not notify the Claims Administrator in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Benefits will not be paid.

To continue reading, go to right column on this page.

Benefits for Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify the Claims Administrator, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

Limitations on Selection of Providers

If the Claims Administrator determines that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, you may be required to select a single Network Physician to provide and coordinate all future Covered Health Services.

If you don't make a selection within 31 days of the date the Plan Administrator notifies you, the Claims Administrator will select a single Network Physician for you. If you fail to use the selected Network Physician, Benefits for Covered Health Services will not be paid.

Emergency Health Services

The Plan Administrator provides Benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

Benefits are paid for Emergency Health Services, even if the services are provided by a non-Network provider.

If you are confined in a non-Network Hospital after you receive Emergency Health Services, the Claims Administrator must be

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notified within one business day or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Benefits will not be available.

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Section 4: When Coverage Begins

This section includes information about:

- How to enroll.
- If you are hospitalized when this coverage begins.
- Who is eligible for coverage.
- When to enroll.
- When coverage begins.

How to Enroll

To enroll, the Eligible Person must complete enrollment information. The Plan Administrator or its designee will give the necessary information to you, along with instructions about submitting your enrollment information and any required contribution for coverage. The Plan Administrator will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan Administrator will pay Benefits for Covered Health Services

To continue reading, go to right column on this page.

related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan. Coverage is subject to pre-existing conditions exclusion applicable to the Plan.

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

If You Are Eligible for Medicare

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you **should** enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if the Plan Administrator is the secondary payer as described in (Section 7: Coordination of Benefits), the Plan Administrator will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare+Choice (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you **should** follow all rules of that plan that require you to seek services from that plan's participating providers. When the Plan Administrator is the secondary payer, the Plan Administrator will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare+Choice plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

To continue reading, go to left column on next page.

Who is Eligible for Coverage

| Who | Description | Who Determines Eligibility |
|------------------------|---|--|
| Eligible Person | <p>Eligible Person usually refers to an employee of ours who meets the eligibility rules. When an Eligible Person actually enrolls, the Plan Administrator refers to that person as a Participant. If both spouses are Eligible Persons under the Plan, each may enroll as a Participant or be covered as an Enrolled Dependent of the other, but not both.</p> <p>Except as the Plan Administrator has described in (Section 4: When Coverage Begins), Eligible Persons may not enroll.</p> | <p>The Plan Administrator determines who is eligible to enroll under the Plan.</p> |
| Dependent | <p>Dependent generally refers to the Participant's spouse and children. When a Dependent actually enrolls, the Plan Administrator refers to that person as an Enrolled Dependent.</p> <p>Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan.</p> <p>If both parents of a Dependent child are enrolled as a Participant, only one parent may enroll the child as a Dependent.</p> <p>Except as the Plan Administrator has described in this Plan.</p> | <p>The Plan Administrator determines who qualifies as a Dependent.</p> |

When to Enroll and When Coverage Begins

| When to Enroll | Who Can Enroll | Begin Date |
|--|---|--|
| <p>Initial Enrollment Period</p> <p>The Initial Enrollment Period is the first period of time when Eligible Persons can enroll.</p> | <p>Eligible Persons may enroll themselves and their Dependents.</p> | <p>Coverage begins on the date identified by the Plan Administrator, if the Plan Administrator receives the completed enrollment form and any required contribution for coverage within 30 days of the date the Eligible Person becomes eligible to enroll.</p> |
| <p>Open Enrollment Period</p> | <p>Eligible Persons may enroll themselves and their Dependents.</p> | <p>The Plan Administrator determines the Open Enrollment Period. Coverage begins on the date identified by the Plan Administrator if the Plan Administrator receives the completed enrollment form and any required contribution within 30 days of the date the Eligible Person becomes eligible to enroll.</p> |
| <p>New Eligible Persons</p> | <p>New Eligible Persons may enroll themselves and their Dependents.</p> | <p>Coverage begins on the date of hire if the Plan Administrator receives the properly completed enrollment form and any required contribution for coverage within 30 days of the date the new Eligible Person becomes eligible to enroll and if the Participant pays any required contribution to the Plan Administrator for Coverage.</p> <p>Retiree Coverage: Coverage begins on the first of the month following the termination date of employment if the Plan Administrator receives the properly completed enrollment form and any required contribution for coverage within 30 days after</p> |

the date of retirement. Otherwise, the retired employee will be considered to have waived retiree coverage and will not be eligible for future coverage.

Adding New Dependents

Participants may enroll Dependents because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- Domestic Partner

Coverage begins on the date of the event if the Plan Administrator received the completed enrollment form and any required contribution for coverage within 30 days of the event that makes the new Dependent eligible.

Documentation is required to validate all Dependents.

Special Enrollment Period

An Eligible Person (who has not enrolled) and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.

A special enrollment period applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true:

- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and
- Coverage under the prior plan ended because of any of the following:
 - Loss of eligibility (including, without limitation, legal separation, divorce or death).
 - The employer stopped paying the contributions.
 - In the case of COBRA continuation coverage, the coverage ended.
 - The Eligible Person and/or Dependent no longer lives or works in an HMO service

Event Takes Place (for example, a birth or marriage). Coverage begins on the date of the effective date.

Missed Initial Enrollment Period or Open Enrollment Period. Coverage begins on the day immediately following the day coverage under the prior plan ends if the Plan Administrator receives the completed enrollment form and any required contribution within 30 days of the date coverage under the prior plan ended.

When to Enroll**Who Can Enroll****Begin Date**

area if no other benefit option is available.

- The Plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
- An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.

Section 5: How to File a Claim

This section provides you with information about:

- How and when to file a claim.
- If you receive Covered Health Services from a Network provider, you do not have to file a claim. The Plan Administrator pays these providers directly.
- If you receive Covered Health Services from a non-Network provider, you may be responsible for filing a claim.

If You Receive Covered Health Services from a Network Provider

The Plan Administrator pays Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact the Claims Administrator. However, you are responsible for paying Copayments to a Network provider at the time of service, or when you receive a bill from the provider.

Filing a Claim for Benefits

When you receive Covered Health Services from a non-Network provider as a result of an Emergency, you may be responsible for requesting payment from the Plan Administrator through the Claims

To continue reading, go to right column on this page.

Administrator. You must file the claim in a format that contains all of the information required, as described below.

If the Network provider does not file the claim, you must submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to the Claims Administrator within one year of the date of service, Benefits for that health service will be denied or reduced, in our or the Claims Administrator's discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Pharmacy Benefit Claims

If you are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy and you believe that the Plan should have paid for it, you may submit a claim for reimbursement as set forth in the procedures for filing a post-service group health plan claim (described in this section). If you pay a Copayment and you believe that the amount of the Copayment was incorrect, you also may submit a claim for reimbursement as set forth in the procedures for filing a post-service group health plan claim.

If a retail or mail order pharmacy fails to fill a prescription that you have presented, you may contact the Claims Administrator by submitting a claim for coverage as set forth in the procedures for filing a pre-service health plan claim (described in this section).

Required Information

When you request payment of Benefits from the Plan Administrator, you must provide all of the following information:

- A. Participant's name and address.
- B. The patient's name, age and relationship to the Participant.
- C. The member number stated on your ID card.

To continue reading, go to left column on next page.

- D. An itemized bill from your provider that includes the following:
- Patient diagnosis
 - Date of service
 - Procedure code(s) and description of service(s) rendered
 - Provider of service (Name, Address and Tax Identification Number)
- E. The date the Injury or Sickness began.
- F. 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 of the other carrier(s).

Payment of Benefits

Through the Claims Administrator, the Plan Administrator will make a benefit determination as set forth below.

You may not assign your Benefits under the Plan to a non-Network provider without our consent. The Claims Administrator may, however, in their discretion, pay a non-Network provider directly for services rendered to you.

The Claims Administrator will notify you if additional information is needed to process the claim. The Claims Administrator may request a one time extension not longer than 15 days and will pend your claim until all information is received. Once you are notified of the extension or missing information, you then have at least 45 days to provide this information.

Benefit Determinations

Post-Service Claims

To continue reading, go to right column on this page.

Post-Service Claims are those claims that are filed for payment of benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30-day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Pre-Service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, you will receive written notice of the decision from the Claims Administrator within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, the Claims Administrator will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15

To continue reading, go to left column on next page.

days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the appeal procedures.

Urgent Requests for Benefits that Require Immediate Action

Urgent requests for Benefits are those that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72 hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If you filed an urgent request for Benefits improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, the Claims Administrator will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

To continue reading, go to right column on this page.

You will be notified of a determination no later than 48 hours after:

- The Claims Administrator's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the appeal procedures.

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 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. The Claims Administrator 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 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.

To continue reading, go to left column on next page.

Section 6: Questions, Complaints and Appeals

This section provides you with information to help you with the following:

- You have a question or concern about Covered Health Services or your Benefits.
- You have a complaint.
- How to handle an appeal that requires immediate action.
- You are notified that a claim has been denied because it has been determined that a service or supply is excluded under the Plan and you wish to appeal such determination.

To resolve a question or appeal, just follow these steps:

What to Do First

If your question or concern is about a benefit determination, you may informally contact Customer Service before requesting a formal appeal. If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in (Section 5: How to File a Claim) you

To continue reading, go to right column on this page.

may appeal it as described below, without first informally contacting Customer Service. If you first informally contact Customer Service and later wish to request a formal appeal in writing, you should contact Customer Service and request an appeal. If you request a formal appeal, a Customer Service representative will provide you with the appropriate address of the Claims Administrator.

If you are appealing an urgent care claim denial, please refer to the "Urgent Appeals that Require Immediate Action" section below and contact Customer Service immediately.

The Customer Service telephone number is shown on your ID card. Customer Service representatives are available to take your call.

How to Appeal a Claim Decision

If you disagree with a pre-service request for Benefits determination or post-service claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal.

Your request should include:

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

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

To continue reading, go to left column on next page.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator (first level appeals) and the Plan Administrator (second level appeals) may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon your request and free of charge, you have the right to reasonable access to (including copies of) all documents, records, and other information relevant to your claim for Benefits.

Appeals Determinations

Pre-Service Requests for Benefits and Post-Service Claim Appeals

You will be provided written or electronic notification of decision on your appeal as follows:

For appeals of pre-service requests for Benefits as defined in (Section 5: How to File a Claim), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. The second level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of post-service claims as defined in (Section 5: How to File a Claim), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second

To continue reading, go to right column on this page.

level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent requests for Benefits, see "Urgent Appeals that Require Immediate Action" below.

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Plan Administrator. Your second level appeal request must be submitted to the Plan Administrator in writing within 60 days from receipt of the first level appeal decision.

The Plan Administrator has the exclusive right to interpret and administer the Plan, and these decisions are conclusive and binding.

Please note that our decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

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. In these urgent situations:

The appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt by the

To continue reading, go to left column on next page.

Claims Administrator of your request for review of the determination taking into account the seriousness of your condition.

For urgent requests for Benefits appeals, the Plan Administrator has delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Plan. The Claims Administrator's decisions are conclusive and binding.

To continue reading, go to right column on this page.

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To continue reading, go to left column on next page.

Section 7: When Coverage Ends

An Enrolled Dependent's coverage ends on the date the Participant's coverage ends.

This section provides you with information about all of the following:

- Events that cause coverage to end.
- The date your coverage ends.
- Extended coverage.
- Continuation of coverage under federal law (COBRA).

General Information about When Coverage Ends

The Plan Administrator may discontinue this benefit Plan and/or all similar benefit plans at any time.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, the Plan Administrator will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, the Plan Administrator does not provide Benefits for health services that you receive for medical conditions that occurred before your coverage ended, even if the underlying medical condition occurred before your coverage ended.

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified in the following table:

| Ending Event | What Happens |
|---|--|
| The Entire Plan Ends | Your coverage ends on the date the Plan ends. The Plan Administrator is responsible for notifying you that your coverage has ended. |
| You Are No Longer Eligible | Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Participant or Enrolled Dependent. |
| The Claims Administrator Receives Notice to End Coverage | Your coverage ends on the last day of the calendar month in which the Claims Administrator receives written notice from the Plan Administrator instructing the Claims Administrator to end your coverage, or the date requested in the notice, if later. |

Other Events Ending Your Coverage

When any of the following happens, the Plan Administrator will provide written notice to the Participant that coverage has ended on the date the Plan Administrator identifies in the notice:

| Ending Event | What Happens |
|--|--|
| Fraud, Misrepresentation or False Information | Fraud or misrepresentation, or because the Participant knowingly gave the Plan Administrator or the Claims Administrator false material information. Examples include false information relating to another person's eligibility or status as a Dependent. During the first two years the Plan is in effect, the Plan Administrator has the right to demand that you pay back all Benefits the Plan Administrator paid to you, or paid in your name, during the time you were incorrectly covered under the Plan. After the first two years, the Plan Administrator can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement. |
| Material Violation | There was a material violation of the terms of the Plan. |
| Improper Use of ID Card | You permitted an unauthorized person to use your ID card, or you used another person's card. |
| Failure to Pay | You failed to pay a required contribution. |
| Threatening Behavior | You committed acts of physical or verbal abuse that pose a threat to our staff, the Claims Administrator's staff, a provider, or other Covered Persons. |

Coverage for a Handicapped Child

Coverage for an unmarried Enrolled Dependent child who is not able to be self-supporting because of mental retardation or a physical handicap will not end just because the child has reached a certain age. The Plan Administrator will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental retardation or physical handicap.
- Depends mainly on the Participant for support.

Coverage will continue as long as the Enrolled Dependent is incapacitated and dependent unless coverage is otherwise terminated in accordance with the terms of the Plan.

The Plan Administrator will ask you to furnish the Claims Administrator with proof of the child's incapacity and dependency within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before the Claims Administrator agrees to this extension of coverage for the child, the Claims Administrator may require that a Physician chosen by the Plan Administrator examine the child. The Plan Administrator will pay for that examination.

The Claims Administrator may continue to ask you for proof that the child continues to meet these conditions of incapacity and dependency. Such proof might include medical examinations at our expense. However, the Plan Administrator will not ask for this information more than once a year.

If you do not provide proof of the child's incapacity and dependency within 31 days of the Claims Administrator's request as described above, coverage for that child will end.

Leave of Absence

Employees on an approved leave of absence and who are not receiving a regular pay check should make arrangements to pay any required contribution for coverage. If any required contribution is not paid when due, past due contributions will accrue in arrears and be deducted from the employee's paycheck upon return to work. Coverage will be canceled for non-payment and claims will not be processed for the time period when contributions are past due beyond 60 days. Employees on Military leave have the option to retain or cancel coverage by contacting the Benefit Service Center (BSC) within thirty-one days. The employee returning from Military leave must call BSC within 30 days of return to work in order to reinstate coverage.

Reinstatement of Coverage Following Inactive Status

If your coverage under the Plan was terminated after a period of layoff, approved leave of absence or during part-time status, and you are now returning to work, your coverage is effective immediately on the day you return to work. The pre-existing condition limitation will be waived with respect to the reinstatement of your coverage.

If your coverage under the Plan was terminated due to a period of total disability or service in the uniformed services covered under the Uniformed Services Employment and Reemployment Rights Act of 1994, your coverage is effective immediately on the day you return to work. Both the eligibility period requirement and the pre-existing condition limitation will be waived with respect to the reinstatement of your coverage.

Survivorship Coverage

If the employee dies while covered under the Plan, the surviving spouse and any eligible dependents may continue coverage under the Plan until the end of the month following a period of 90 days subsequent to the employee's death. After the initial 90 days following the employee's date of death, coverage is then available to the surviving spouse and any eligible dependents through the COBRA provision, except for a surviving spouse of an active uniformed officer killed in the line of duty. A surviving spouse of an active uniformed officer may continue coverage on the existing plan at active rates. If a surviving spouse remarries, coverage under the Plan will terminate.

A surviving spouse who is covered under a retiree Plan may continue coverage as long as he/she is eligible for pension benefits. Any dependents acquired through the remarriage of a retired employee's surviving spouse will not be eligible for coverage under the Plan.

A surviving spouse and eligible dependents of a retired employee may remain in the Plan after the death of the retired employee:

- If the person was covered as a dependent spouse of the deceased retired employee at the time of the retired employee's death and is eligible to receive pension benefits;
- If carried as a dependent child, the person remains a dependent of the surviving spouse, but only if the spouse is receiving monthly survivor's benefits from one of the retirement funds.

Coverage for all surviving dependents ceases if coverage for the surviving spouse stops because of death, termination of monthly benefits, or any other reason.

A retired employee, or a surviving spouse or dependent who is eligible for Medicare participation by reason of age or disability or any other reason, must enroll and remain enrolled in Medicare Parts A and B in order to retain eligibility in the Plan.

The City will pay the Medicare Part A monthly premium on behalf of the retired employees and spouses of retired employees who are not otherwise qualified for Medicare. Retired employees are responsible for notifying the City, otherwise, they will be responsible for payment of the Medicare Part A premium. The retired employee and retired employee's spouse are responsible for payment of all Medicare Part B premiums.

If a retired employee is enrolled in this Plan on January 1, and elects to discontinue coverage in this Plan, the retired employee will not be eligible to enroll at a later date or in a subsequent plan

Continuation of Coverage

If your coverage ends under the Plan, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal law.

Riders, Amendments, Notices

Outpatient Prescription Drug Rider

EPO Plan

Outpatient Prescription Drug Rider

Table of Contents

Outpatient Prescription Drug Rider 1

Introduction..... 2

Benefits for Outpatient Prescription Drug Products2
 Coverage Policies and Guidelines2
 Identification Card (ID Card) - Network Pharmacy2
 Designated Pharmacies3
 Limitation on Selection of Pharmacies.....3
 Rebates and Other Payments.....3
 Coupons, Incentives and Other Communications3

Section 1: What's Covered--Prescription

Drug Benefits 4

Benefits for Outpatient Prescription Drug Products4
 When a Brand-name Drug Becomes Available as a Generic.....4
 Supply Limits.....4
 Notification Requirements4
 What You Must Pay5
 Payment Information6
 Copayment.....6
 Benefit Information.....7
 Prescription Drugs from a Retail Network Pharmacy7

Prescription Drug Products from a Home Delivery Network
 Pharmacy..... 7

Section 2: What's Not Covered--Exclusions9

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

Outpatient Prescription Drug Rider

This Rider to the Plan Summary of Benefits provides Benefits for outpatient Prescription Drug Products.

Benefits are provided for outpatient Prescription Drug Products at a Network Pharmacy.

Because this Rider is part of a legal document, the Plan Administrator wants to give you information about the document that will help you understand it. Certain capitalized words have special meanings

When the words "you" and "your" are used, they are referring to people who are Covered Persons as the term is defined in the Plan Summary of Benefits.

NOTE: The Coordination of Benefits provision (Section 7: Coordination of Benefits) in the Plan Summary of Benefits does not apply to Prescription Drug Products covered through this Rider. Prescription Drug Product Benefits will not be coordinated with those of any other health coverage plan.

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

Introduction

Benefits for Outpatient Prescription Drug Products

Benefits are available for Outpatient Prescription Drug Products on the Prescription Drug List at a Network Pharmacy and are subject to Copayments or other payments that vary depending on which of the three tiers of the Prescription Drug List the Outpatient Prescription Drug is listed.

Coverage Policies and Guidelines

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

The Claims Administrator, with the acknowledgement of the Plan Administrator, may change the placement of a Prescription Drug Product to a higher tier (Up Tiering) and or exclude a Drug Product

To continue reading, go to right column on this page.

from the PDL, annually, at the beginning of the policy year. Down Tiering of a Prescription Drug Product, may occur quarterly, but no more than six times per calendar year.

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

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

Identification Card (ID Card) - Network Pharmacy

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

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from the Plan Administrator as described in Plan Summary of Benefits (Section 5: How to File a Claim). When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription

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Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment and any deductible that applies.

Designated Pharmacies

If you require certain Prescription Drug Products, the Claims Administrator may direct you to a Designated Pharmacy with whom they have an exclusive arrangement to provide those Prescription Drug Products.

In this case, Benefits will only be paid if your Prescription Order or Refill is obtained from the Designated Pharmacy.

Limitation on Selection of Pharmacies

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

Rebates and Other Payments

The Claims Administrator may receive rebates for certain drugs included on the Prescription Drug List. The Claims Administrator does not pass these rebates on to you, nor are they taken into account in determining your Copayments.

The Claims Administrator, and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers

To continue reading, go to right column on this page.

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

Coupons, Incentives and Other Communications

At various times, the Plan Administrator or the Claims Administrator may send mailings to you or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you, at your discretion, to purchase the described drug product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

To continue reading, go to left column on next page.

Section 1: What's Covered-- Prescription Drug Benefits

The Plan Administrator provides Benefits under the Plan for outpatient Prescription Drug Products:

- Designated as covered at the time the Prescription Order or Refill is dispensed when obtained from a Network Pharmacy.
- Refer to exclusions in your Plan Summary of Benefits (Section 2: What's Not Covered--Exclusions) and as listed in Section 2 of this Rider.

Benefits for Outpatient Prescription Drug Products

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

To continue reading, go to right column on this page.

When a Brand-name Drug Becomes Available as a Generic

When a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment may change. You will pay the Copayment applicable for the tier to which the Prescription Drug Product is assigned.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description of Pharmacy Type and Supply Limits" column of the Benefit Information table. For a single Copayment, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that the Claims Administrator has developed, subject to its periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

You may determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing through the Internet at www.myuhc.com or by calling Customer Service at the telephone number on your ID card.

Notification Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to notify the Claims Administrator or its designee. The reason for notification is to determine whether the Prescription Drug Product, in

To continue reading, go to left column on next page.

accordance with the Plan Administrator's approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service.
- It is not Experimental, Investigational or Unproven.

Network Pharmacy Notification

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying the Claims Administrator.

If the Claims Administrator is not notified before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring notification are subject to periodic review and modification. You may determine whether a particular Prescription Drug Product requires notification through the Internet at www.myuhc.com or by calling the Customer Service number on your ID card.

If the Claims Administrator is not notified before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from us as described in the Plan Summary of Benefits (Section 5: How to File a Claim).

When you submit a claim on this basis, you may pay more because you did not notify the Claims Administrator before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment and any deductible that applies.

To continue reading, go to right column on this page.

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

What You Must Pay

You are responsible for paying the applicable Copayment described in the Benefit Information table when Prescription Drug Products are obtained from a retail or home delivery pharmacy.

The amount you pay for any of the following under this Rider will not be included in calculating **any Out-of-Pocket Maximum stated in your Plan Summary of Benefits:**

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

To continue reading, go to left column on next page.

Payment Information

| Payment Term | Description | Amounts |
|------------------|--|---|
| Copayment | <p>Copayments for a Prescription Drug Product at a Network Pharmacy can be either a specific dollar amount or a percentage of the Prescription Drug Cost.</p> <p>Your Copayment is determined by the tier to which the Claims Administrator's Prescription Drug List Management Committee has assigned a Prescription Drug Product.</p> <p>NOTE: The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Claims Administrator's Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, your Copayment may change. Please access www.myuhc.com through the Internet, or call the Customer Service number on your ID card for the most up-to-date tier status.</p> | <p>For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of:</p> <ul style="list-style-type: none"> • The applicable Copayment or • The Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug Product. <p>For Prescription Drug Products from a home delivery Network Pharmacy, you are responsible for paying the lower of:</p> <ul style="list-style-type: none"> • The applicable Copayment or • The Prescription Drug Cost for that Prescription Drug Product. <p><i>See the Copayments stated in the Benefit Information table for amounts.</i></p> |

Benefit Information

Description of Pharmacy Type and Supply Limits

Your Copayment Amount

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for outpatient Prescription Drug Products dispensed by a retail Network Pharmacy. The following supply limits apply:

- As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.
- A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Copayment for each cycle supplied.

Your Copayment is determined by the tier to which the Claims Administrator's Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access www.myuhc.com through the Internet, or call the Customer Service number on your ID card to determine tier status.

\$10 per Prescription Order or Refill for a **Tier-1 Prescription Drug Product**.

\$25 per Prescription Order or Refill for a **Tier-2 Prescription Drug Product**.

\$40 per Prescription Order or Refill for a **Tier-3 Prescription Drug Product**.

Prescription Drug Products from a Home Delivery Network Pharmacy

Benefits are provided for outpatient Prescription Drug Products dispensed by a home delivery Network Pharmacy. The following supply limits apply:

- As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

To maximize your Benefit, ask your Physician to write your Prescription Order or

Your Copayment is determined by the tier to which the Claims Administrator's Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access www.myuhc.com through the Internet, or call the Customer Service number on your ID card to determine tier status.

**Description of
Pharmacy Type and Supply Limits**

Your Copayment Amount

Refill for a 90-day supply, with refills when appropriate. You will be charged a home delivery Copayment for any Prescription Orders or Refills sent to the home delivery pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or refill for a 90-day supply, not a 30-day supply with three refills.

For up to a 90-day supply, your Copayment is:

\$20 per Prescription Order or Refill for a **Tier-1 Prescription Drug Product.**

\$50 per Prescription Order or Refill for a **Tier-2 Prescription Drug Product.**

\$80 per Prescription Order or Refill for a **Tier-3 Prescription Drug Product.**

Section 2: What's Not Covered-- Exclusions

Exclusions from coverage listed in the Plan Summary of Benefits apply also to this Rider. In addition, the following exclusions apply:

1. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
3. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
4. Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.
5. Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Claims Administrator to be experimental, investigational or unproven.
6. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

To continue reading, go to right column on this page.

7. Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
8. Any product dispensed for the purpose of appetite suppression and other weight loss products.
9. A specialty medication Prescription Drug Product (including, but not limited to, immunizations and allergy serum) which, due to its characteristics as determined by the Claims Administrator, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
10. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
11. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
12. Unit dose packaging of Prescription Drug Products.
13. Medications used for cosmetic purposes.
14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that are determined to not be a Covered Health Service.
15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
16. Prescription Drug Products when prescribed to treat infertility.
17. Prescription Drug Products for smoking cessation.
18. Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill. Compounded drugs

To continue reading, go to left column on next page.

that contain at least one ingredient that requires a Prescription Order or refill are assigned to Tier-3.

19. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug. Prescription Drug Products that are comprised of components that are available in over-the-counter form or equivalent.
20. New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by the Claims Administrator's Prescription Drug List Management Committee.
21. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
22. Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.

To continue reading, go to right column on this page.

To continue reading, go to left column on next page.

