

Plan Summary of Benefits
70/30 Choice Plus Plan
for
City of Dallas

Group Number: 708872
Effective Date: January 1, 2009

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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

We encourage 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.
- Annual Deductible, 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. You are responsible for notifying the Claims Administrator before you receive certain health services from a non-Network provider.

Accessing Benefits

You can choose to receive either Network Benefits or Non-Network Benefits. In most cases, you must see a Network Physician to obtain Network 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 you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive. For details about when Network Benefits apply, see (Section 3: Description of Network and Non-Network Benefits).

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 occur.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Plan.

Depending on the geographic area and the service you receive, you may have access through the Claims Administrator's Shared Savings Program to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, and if your Copayment is expressed as a percentage of Eligible Expenses for Non-Network Benefits, that percentage will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers than from other non-

Network providers, because the Eligible Expenses may be a lesser amount.

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.

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.

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

Prior notification is required before you receive certain Covered Health Services. In general, Network providers are responsible for notifying the Claims Administrator before they provide these services to you. There are some Network Benefits, however, for which you are responsible for notifying the Claims Administrator.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for notifying the Claims Administrator before you receive these Covered Health Services.

Services for which you must provide prior notification appear in this section under the *Must You Notify the Claims Administrator?* column in the table labeled *Benefit Information*.

To notify the Claims Administrator, call the telephone number on your ID card.

When you choose to receive services from non-Network providers, the Plan Administrator urges you to confirm with the Claims Administrator that the services you plan to receive are Covered Health Services, even if not indicated in the *Must You Notify the Claims Administrator?* column. That's because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions such as:

- The Cosmetic Procedures exclusion. Examples of procedures that may or may not be considered Cosmetic include: breast

reduction and reconstruction (except for after cancer surgery when it is always considered a Covered Health Service); vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty.

- The Experimental, Investigational or Unproven Services exclusion.
- Any other limitation or exclusion of the Plan.

Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services before you are eligible to receive Benefits. The actual amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses.	<u>Network</u> \$3,000 per Covered Person per calendar year, not to exceed \$9,000 for all Covered Persons in a family.
		<u>Non-Network</u> \$6,000 per Covered Person per calendar year, not to exceed \$18,000 for all Covered Persons in a family.
Out-of-Pocket Maximum	The maximum you pay, out of your pocket, in a calendar year for Copayments.	<u>Network</u> \$7,500 per Covered Person per calendar year, not to exceed \$15,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible.
		<u>Non-Network</u> \$15,000 per Covered Person per calendar year, not to exceed \$30,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible.
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.	<u>Network</u> No Maximum Plan Benefit.
		<u>Non-Network</u> No Maximum Plan Benefit.

Benefit Information

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
1. Acupuncture Services Acupuncture services for pain therapy when both of the following are true: <ul style="list-style-type: none"> • Another method of pain management has failed. • The service is performed by an MD in the provider's office. 	<u>Network</u> No	30%	Yes	Yes
	<u>Non-Network</u> No	50%	Yes	Yes
2. Ambulance Services - Emergency only Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.	<u>Network</u> No	<i>Ground Transportation:</i> 30%	Yes	Yes
	<u>Non-Network</u> No	<i>Air Transportation:</i> 30%	Same as Network	Same as Network
		Same as Network	Same as Network	Same as Network

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>3. Cancer Resource Services</p> <p>We will arrange for access to certain of our Network providers that participate in the Cancer Resource Services program for the provision of oncology services. We 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>When these services are not performed in a Cancer Resource Services facility, Benefits will be paid the same as Benefits for <i>Hospital-Inpatient Stay, Outpatient Surgery, Diagnostic and Therapeutic Services, Physician's Office Services, and Professional Fees for Surgical and Medical Services</i> stated in this (Section 1: What's Covered--Benefits).</p>	<p><u>Network</u> Cancer Resource Services must be called.</p> <p><u>Non-Network</u> Non-Network Benefits for the Cancer Resource Services program are not available.</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> <p>Non-Network Benefits for the Cancer Resource Services program are not available.</p>	<p>Non-Network Benefits for the Cancer Resource Services program are not available.</p>	<p>Non-Network Benefits for the Cancer Resource Services program are not available.</p>
<p>4. Dental Services - Accident only</p> <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, 	<p><u>Network</u> Yes</p>	<p>30%</p>	<p>Yes</p>	<p>Yes</p>

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>"D.D.S." or Doctor of Medical Dentistry, "D.M.D.".</p> <ul style="list-style-type: none"> 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 three months of the accident. Completed within 12 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 teeth that are injured as a result of such activities.</p>	<u>Non-Network</u> Yes	Same as Network	Same as Network	Same as Network
Notify the Claims Administrator	Please remember that you must notify the Claims Administrator 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.) If you don't			

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
notify the Claims Administrator, Benefits will be reduced by \$250; however the reduction in Benefits will not exceed Eligible Expenses for the Covered Health Services.				
5. Durable Medical Equipment				
Medical equipment that is all of the following:	<u>Network</u> Yes, for items more than \$750.	30%	Yes	Yes
<ul style="list-style-type: none"> • 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.	<u>Non-Network</u> Yes, for items more than \$750.	50%	Yes	Yes
Examples of Durable Medical Equipment include:				
<ul style="list-style-type: none"> • 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). 				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> • 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. 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 devices. 				

The Plan Administrator and the Claims Administrator will decide if the equipment should be purchased or rented. To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor the Claims Administrator identifies.

Notify the Claims Administrator

Please remember that you must notify the Claims Administrator before obtaining any single item of Durable Medical Equipment that costs more than \$750 (either purchase price or cumulative rental of a single item). If you don't notify the Claims Administrator, you will be responsible for paying all charges and no Benefits will be paid.

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>6. 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>If the services are not for an Emergency as defined, your Copayment amount will be 30% for Network services and 50% for Non-Network services, subject to the deductible.</p> <p>An Emergency is defined as a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:</p> <ul style="list-style-type: none"> • Arises suddenly. • In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health. 	<p><u>Network</u> No</p>	<p>\$100 per visit for the Emergency Room facility;</p> <p>30% for all other services related to the Emergency Room visit</p>	<p>No for the \$100 Emergency Room facility copayment;</p> <p>Yes for the 30% copayment for all other Emergency Room services</p>	<p>No for the Emergency Room facility;</p> <p>Yes for all other Emergency Room services</p>
<p>You will find more information about Benefits for Emergency Health Services in (Section 3: Description of Network and Non-Network Benefits).</p> <p>Note:</p> <p>Reimbursement of Non-Network Emergency Room Physician is determined by the network status of the inpatient hospital or outpatient surgical facility. Network benefits follow the Inpatient Hospital or Outpatient Surgery benefit.</p>	<p><u>Non-Network</u> Yes, but only for an Inpatient Stay.</p>	<p>Same as Network</p>	<p>Same as Network</p>	<p>Same as Network</p>

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Notify the Claims Administrator				
<p>To ensure prompt and accurate payment of your claim as a Network Benefit, notify the Claims Administrator within two business days or as soon as possible after you receive outpatient Emergency Health Services at a non-Network Hospital or Alternate Facility.</p> <p>Please remember that if you are admitted to a non-Network Hospital as a result of an Emergency, you must notify the Claims Administrator within one business day or the same day of admission, or as soon as reasonably possible.</p> <p>If you don't notify the Claims Administrator, Benefits for the Hospital Inpatient Stay will be reduced by \$250; however the reduction in Benefits will not exceed Eligible Expenses for the Covered Health Service. Benefits will not be reduced for the outpatient Emergency Health Services.</p>				

7. Extreme Vision Benefits

The following are covered services:

- Necessary contact lenses or eyeglasses to correct vision problems following cataract surgery.
- The evaluation, fitting cost and purchase cost of contact lenses if there is a diagnosis of Karatoconus.

Benefits are limited to once every 12 months.

Network
No

30%

Yes

Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<hr/>				
	<u><i>Non-Network</i></u>			
	No	50%	Yes	Yes
<hr/>				
8. Home Health Care	<u><i>Network</i></u>			
Services received from a Home Health Agency that are both of the following:	No	30%	Yes	Yes
<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 are provided on a part-time, intermittent schedule and when skilled care is required.	<u><i>Non-Network</i></u>			
	Yes	50%	Yes	Yes
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:				
<ul style="list-style-type: none"> • 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 				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>effectively.</p> <ul style="list-style-type: none"> It is not Custodial Care. <p>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.</p> <p>Any combination of Network and Non-Network Benefits is limited to 30 visits per calendar year. One visit equals four hours of skilled care services.</p> <p style="text-align: center;">Notify the Claims Administrator</p> <p>Please remember that for Non-Network Benefits you must notify the Claims Administrator five business days before receiving services. If you don't notify the Claims Administrator, Benefits will be reduced by \$250; however the reduction in Benefits will not exceed Eligible Expenses for the Covered Health Service.</p>				
<p>9. 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</p>	<u>Network</u> No	30%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>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 style="text-align: center;">Notify the Claims Administrator</p> <p>Please remember that for Non-Network Benefits you must notify the Claims Administrator five business days before receiving services. If you don't notify the Claims Administrator, Benefits will be reduced by \$250; however the reduction in Benefits will not exceed Eligible Expenses for the Covered Health Service.</p>	<u>Non-Network</u> Yes	50%	Yes	Yes
<p>10. 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> <p>Note: Reimbursement of Non-Network radiologist, anesthesiologist, pathologist and laboratory are determined by the network status of the inpatient hospital or outpatient surgical facility. Network benefits</p>	<u>Network</u> No	30%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
follow the Inpatient Hospital or Outpatient Surgery benefit.				
<p align="center">Notify the Claims Administrator</p> <p>Please remember that for Non-Network Benefits you must notify the Claims Administrator as follows:</p> <ul style="list-style-type: none"> • For elective admissions: five business days before admission. • For non-elective admissions: within one business day or the same day of admission. • For Emergency admissions: within one business day or the same day of admission, or as soon as is reasonably possible. <p>If you don't notify the Claims Administrator, Benefits will be reduced by \$250; however the reduction in Benefits will not exceed Eligible Expenses for the Covered Health Service.</p>	<u>Non-Network</u> Yes	50%	Yes	Yes
11. Injections received in a Physician's Office	<u>Network</u> No	30% per injection	Yes	Yes
Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.	<u>Non-Network</u> No	50% per injection	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>12. Maternity Services</p> <p>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 vaginal delivery. • 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><i>For Enrolled Dependent Children only:</i></p> <p>Pregnancy Benefits for Enrolled Dependent children are limited to Covered Health Services for Complications of Pregnancy.</p>	<p><u>Network</u> No</p>	<p>Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.</p>		

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>Benefits are payable for Covered Health Services for the treatment of Complications of Pregnancy provided to an Enrolled Dependent child.</p> <p>Benefits for Complications of Pregnancy are paid in the same way as Benefits for any other condition or Sickness.</p> <p>Benefits for Complications of Pregnancy which result in the delivery of a child are payable for at least:</p> <ul style="list-style-type: none"> • 48 hours of inpatient care for the mother and newborn child following a normal vaginal delivery. • 96 hours of inpatient care for the mother and newborn child following a cesarean section. <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>The following are not considered Complications of Pregnancy:</p> <ul style="list-style-type: none"> • False labor. • Occasional spotting. • Rest prescribed by a Physician. • Morning sickness. • Other conditions that may be connected with a difficult Pregnancy but are not a classifiably distinct complication. 				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p align="center">Notify the Claims Administrator</p> <p>Please remember that for Non-Network Benefits you must notify the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described. If you don't notify the Claims Administrator that the Inpatient Stay will be extended, your Benefits for the extended stay will be reduced by \$250; however the reduction in Benefits will not exceed Eligible Expenses for the Covered Health Service.</p>	<p><u>Non-Network</u> Yes, if Inpatient Stay exceeds time frames.</p>	<p>Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.</p>		
<p>13. 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><u>Network</u> You must call the Mental Health/ Substance Abuse Designee to receive the Benefits.</p>	<p>30%</p>	<p>No</p>	<p>Yes</p>

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>For Network Benefits, 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 Network Benefits for outpatient Mental Health and Substance Abuse Services.</p>	<p><u>Non-Network</u> You must call the Mental Health/Substance Abuse Designee to receive the Benefits.</p>	<p>50%</p>	<p>No</p>	<p>Yes</p>
<p>Any combination of Network and Non-Network Benefits for Mental Health Services is limited to 20 visits per calendar year.</p>				
<p>Any combination of Network and Non-Network Benefits for Serious Mental Health Services is limited to 60 visits per calendar year.</p>				
<p>Any combination of Network and Non-Network Benefits for Substance Abuse Services is limited to 3 series per lifetime.</p>				
<p>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>				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>14. 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 to protect your physical health and well-being.</p> <p>The Mental Health/Substance Abuse Designee, who will authorize 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.</p> <p>Network Benefits for Mental Health Services and Substance Abuse Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. For Network Benefits, 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.</p> <p>Any combination of Network and Non-Network Benefits for Mental Health Services is limited to 30 visits per calendar year.</p> <p>Any combination of Network and Non-Network Benefits for</p>	<p><u>Network</u> You must call the Mental Health/ Substance Abuse Designee to receive the Benefits.</p>	30%	No	Yes
	<p><u>Non-Network</u> You must call the Mental Health/ Substance Abuse Designee to receive the Benefits.</p>	50%	No	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>Serious Mental Health Services is limited to 45 visits per calendar year</p> <p>Any combination of Network and Non-Network Benefits for Substance Abuse Services is limited to 3 series per lifetime.</p>				
Authorization Required				
<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>				
15. Nutritional Counseling				
<p>Covered Health Services provided by a registered dietician in an individual session for Covered Persons with diabetes that require a special diet.</p>	<u>Network</u>	30%	Yes	Yes
	No			
	<u>Non-Network</u>	50%	Yes	Yes
	No			

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
16. Ostomy Supplies	<u>Network</u>			
Benefits for ostomy supplies include only the following:	No	30%	Yes	Yes
<ul style="list-style-type: none"> • Pouches, face plates and belts. • Irrigation sleeves, bags and catheters. • Skin barriers. 				
	<u>Non-Network</u>			
Benefits are not available for gauze, adhesive, adhesive remover, deodorant, pouch covers, or other items not listed above.	No	50%	Yes	Yes
17. Outpatient Surgery, Diagnostic and Therapeutic Services				
<p>Note: Reimbursement of Non-Network radiologist, anesthesiologist, pathologist and laboratory are determined by the network status of the inpatient hospital or outpatient surgical facility. Network benefits follow the Inpatient Hospital or Outpatient Surgery benefit.</p>				
Outpatient Surgery	<u>Network</u>			
Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:	No	30%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> Benefits under this section include only the facility charge and the charge for required Hospital-based professional services, supplies and equipment. Benefits for the surgeon fees related to outpatient surgery are described under <i>Professional Fees for Surgical and Medical Services</i>. 	<u>Non-Network</u>	50%	Yes	Yes
<p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> below.</p>	No			
<p><i>Outpatient Diagnostic Services</i> Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:</p>	<u>Network</u>	<i>For lab and radiology/ X-ray:</i>		
<ul style="list-style-type: none"> Lab and radiology/X-ray. Mammography testing. Routine mammograms are limited to 1 each calendar year, starting at age 35. 	No	30%	Yes	Yes
<p>Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.</p>	No	<i>For mammography testing:</i>		
<p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> below. However, Non-Network services performed in a Non-Network Physician's office will be paid at the non-network level described in Physician's Office Services below unless the claim system search in history finds a network office service within 15 days prior to the Non-Network services. If a network service is found it will pay at the Network</p>		30%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
level.				
This section does not include Benefits for CT scans, PET scans, MRIs, or nuclear medicine, which are described immediately below.	<u><i>Non-Network</i></u> No	50%	Yes	Yes
<i>Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine</i>	<u><i>Network</i></u> No	30%	Yes	Yes
Covered Health Services for CT scans, PET scans, MRI, and nuclear medicine received on an outpatient basis at a Hospital or Alternate Facility.				
Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.	<u><i>Non-Network</i></u> No	50%	Yes	Yes
<i>Outpatient Therapeutic Treatments</i>	<u><i>Network</i></u> No	30%	Yes	Yes
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.				
Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.	<u><i>Non-Network</i></u> No	50%	Yes	Yes
When these services are performed in a Physician's office, Benefits				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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are described under *Physician's Office Services* below.

18. Physician's Office Services

Covered Health Services for preventive medical care.

Preventive medical care includes:

- Voluntary family planning.
- Well-baby and well-child care.
- Routine physical examinations.
- Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment.)
- Immunizations.

Routine exams and screenings are subject to the following limits:

- 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.
- Annual blood pressure screening for ages 17 and up.
- Colonoscopy once every 5 years for males and females ages 50 and up.
- Annual cholesterol screening for men ages 30 to 65.
- Cholesterol screening every 2 years for women ages 40 to 65.

Network

No

30%

Yes

Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> - 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 ages 17 and up. - Immunizations – Influenza annually for ages 17 and up. - Immunizations – Hepatitis A/B for any person at risk. <p data-bbox="205 623 835 656">Follow-up visits do not count as a Preventive Visit.</p>	<u>Non-Network</u> No	50%	Yes	Yes
Covered Health Services for the diagnosis and treatment of a Sickness or Injury received in a Physician's office.	<u>Network</u> No	30%	Yes	Yes
	<u>Non-Network</u> No	50%	Yes	Yes
19. Professional Fees for Surgical and Medical Services	<u>Network</u> No	30%	Yes	Yes
Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Rehabilitation Facility or Alternate Facility, or for Physician house calls.				
When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> above.	<u>Non-Network</u> No	50%	Yes	Yes
20. Prosthetic Devices				
External prosthetic devices that replace a limb or an external body part, limited to:	<u>Network</u> No	30%	Yes	Yes
<ul style="list-style-type: none"> • 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. 				
If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.	<u>Non-Network</u> No	50%	Yes	Yes
The prosthetic device must be ordered or provided by, or under the direction of a Physician. Except for items required by the Women's Health and Cancer Rights Act of 1998.				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>21. 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 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</p>	<u>Network</u>	No	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.	
	<u>Non-Network</u>	Yes	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.	

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>at the telephone number on your ID card for more information about Benefits for mastectomy-related services.</p> <p style="text-align: center;">Notify the Claims Administrator</p> <p>Please remember that for Non-Network Benefits you must notify the Claims Administrator five business days before receiving services. When you provide notification, the Claims Administrator can verify that the service is a reconstructive procedure rather than a Cosmetic Procedure. Cosmetic Procedures are always excluded from coverage. If you don't notify the Claims Administrator, Benefits for reconstructive procedures will be reduced by \$250; however the reduction in Benefits will not exceed Eligible Expenses for the Covered Health Service.</p>				
<p>22. Rehabilitation Services - Outpatient Therapy</p>	<u>Network</u> No	30%	Yes	Yes
<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. 				
<p>Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician.</p>	<u>Non-Network</u> No	50%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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.				
Please note that the Plan Administrator will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly.				
Any combination of Network and Non-Network Benefits is limited as follows:				
<ul style="list-style-type: none"> • 20 visits of physical therapy per calendar year. • 20 visits of occupational therapy per calendar year. • 20 visits of speech therapy per calendar year. 				

23. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

<i><u>Network</u></i>			
No	30%	Yes	Yes

Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Services and supplies received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).

Any combination of Network and Non-Network Benefits is limited to 120 days per calendar year.

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital.</p> <p style="text-align: center;">Notify the Claims Administrator</p> <p>Please remember that for Non-Network Benefits you must notify the Claims Administrator as follows:</p> <ul style="list-style-type: none"> • For elective admissions: five business days before admission. • For non-elective admission: within one business day or the same day of admission. • For Emergency admissions: within one business day or the same day of admission, or as soon as is reasonably possible. <p>If you don't notify the Claims Administrator, Benefits will be reduced by \$250; however the reduction in Benefits will not exceed Eligible Expenses for the Covered Health Service.</p>	<u>Non-Network</u> Yes	50%	Yes	Yes
<p>24. Spinal Treatment</p> <p>Benefits for Spinal Treatment when provided by a Spinal Treatment provider in the provider's office.</p>	<u>Network</u> No	30%	Yes	Yes
<p>Benefits include diagnosis and related services and are limited to one visit and treatment per day.</p>	<u>Non-Network</u> No	50%	Yes	Yes
<p>Any combination of Network and Non-Network Benefits for Spinal Treatment is limited to 20 visits per calendar year.</p>				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>25. Temporomandibular Joint Dysfunction (TMJ) Covered Health Services for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Benefits include necessary diagnostic or surgical treatment required as a result of accident, trauma, congenial defect, developmental defect, or pathology.</p> <p>Benefits are not available for charges or services that are dental in nature.</p>	<p><u>Network</u> No</p>	<p>Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Diagnostic and Therapeutic Services.</p>		
<p>Benefits are not available for charges or services that are dental in nature.</p>	<p><u>Non-Network</u> No</p>	<p>Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Diagnostic and Therapeutic Services.</p>		
<p>26. Transplantation Services Covered Health Services for the following organ and tissue transplants when ordered by a Physician. For Network Benefits, transplantation services must be received at a Designated Facility. Transplantation services provided at a non-Designated Facility will be covered as Non-Network Benefits. 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> <p>The Copayment and Annual Deductible will not apply to Network Benefits when a transplant listed below is received at a Designated Facility. The services described under Transportation and Lodging below are Covered Health Services ONLY in connection</p>	<p><u>Network</u> Yes</p>	<p>30%</p>	<p>Yes</p>	<p>Yes</p>

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
with a transplant received at a Designated Facility.				
<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. The search for bone marrow/stem cell from a donor who is not biologically related to the patient is a Covered Health Service only for a transplant received at a Designated Facility. Heart transplants. Heart/lung transplants. Lung transplants. Kidney transplants. Kidney/pancreas transplants. Liver transplants. Liver/small bowel transplants. Pancreas transplants. Small bowel transplants. 	<u>Non-Network</u> Yes	50%	Yes	Yes
<p>Network Benefits are also available for cornea transplants that are provided by a Network Physician at a Network Hospital. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits. For cornea transplants, Benefits will be paid at the same level as <i>Professional Fees for Surgical and Medical Services, Outpatient Surgery, Diagnostic and Therapeutic Services,</i></p>				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
and <i>Hospital - Inpatient Stay</i> rather than as described in this section " <i>Transplantation Services</i> ".				
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 only 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:				
<ul style="list-style-type: none"> • 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. • 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 per person. • 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 				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the \$75 per diem rate.</p> <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 style="text-align: center;">Notify the Claims Administrator</p> <p>You must notify the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you do not notify the Claims Administrator, and if the transplantation services are not performed at a Designated Facility, you will be responsible for paying all charges and Network Benefits will not be paid. Non-Network Benefits may be available.</p> <p>Please remember that for Non-Network Benefits you must notify the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't notify the Claims Administrator, Benefits will be reduced by \$250; however the reduction in Benefits will not exceed Eligible Expenses for the Covered Health Service.</p>				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
27. 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 Physician's office, Benefits are available as described under <i>Physician's Office Services</i> earlier in this section.	<u>Network</u> No	30%	Yes	Yes
	<u>Non-Network</u> No	50%	Yes	Yes

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 calls 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 Do not Pay Benefits for Exclusions

We 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.
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.

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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.

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6. Shoe orthotics.

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

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will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by 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

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other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

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.

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5. Wigs regardless of the reason for the hair loss.

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. Health services and associated expenses for infertility treatments.
2. Surrogate parenting.
3. The reversal of voluntary sterilization.
4. Health services and associated expenses for elective abortion.
5. Contraceptive supplies and services.
6. Fetal reduction surgery.
7. Health services associated with the use of non-surgical or drug-induced Pregnancy termination.
8. Pregnancy-related services for an Enrolled Dependent child other than treatment for Complications of Pregnancy

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.

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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 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. Any solid organ transplant that is performed as a treatment for cancer.
5. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Health 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 hearing aids, eye glasses or contact lenses.
2. Fitting charge for hearing aids, 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.
5. Routine vision examinations, including refractive examinations.

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R. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service.
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. In the event that a non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments and/or Annual Deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered to be dental in nature.
9. 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 and as provided in Section 1.
10. Non-surgical treatment of obesity, including morbid obesity.
11. Surgical treatment of obesity. Surgical treatment of morbid obesity is covered if any of the following exists: severe morbid obesity (with a BMI greater than 40); morbid obesity with 100 pounds over ideal body weight and 30% over ideal body weight with underlying medical condition. Surgery is limited to \$5,000 per calendar year.
12. Growth hormone therapy.
13. Sex transformation operations.
14. Custodial Care.
15. Domiciliary care.
16. Private duty nursing provided on an inpatient basis.
17. Respite care.
18. Rest cures.
19. Psychosurgery.
20. Treatment of benign gynecomastia (abnormal breast enlargement in males).
21. Medical and surgical treatment of excessive sweating (hyperhidrosis).
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, or a Congenital Anomaly.

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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: Description of Network and Non-Network Benefits

This section includes information about:

- Network Benefits.
- Non-Network Benefits.
- Emergency Health Services.

Network Benefits

Network Benefits are generally paid at a higher level than Non-Network Benefits. Network Benefits are payable for Covered Health Services which are either of the following:

- Provided by a Network Physician, Network facility, or other Network provider.
- Emergency Health Services.

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*.

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Comparison of Network and Non-Network Benefits

	Network	Non-Network
Benefits	A higher level of Benefits means less cost to you. See (Section 1: What's Covered--Benefits).	A lower level of Benefits means more cost to you. See (Section 1: What's Covered--Benefits).
Who Should Notify the Claims Administrator for Care Coordination	Network providers generally handle notification for you. However, there are exceptions. See (Section 1: What's Covered--Benefits), under the <i>Must You Notify the Claims Administrator?</i> column.	You must notify the Claims Administrator for certain Covered Health Services. Failure to notify results in reduced Benefits or no Benefits. See (Section 1: What's Covered--Benefits), under the <i>Must You Notify the Claims Administrator?</i> column.
Who Should File Claims	Not required. The Plan Administrator pays Network providers directly.	You must file claims. See (Section 5: How to File a Claim).

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	Network	Non-Network
Outpatient Emergency Health Services	Emergency Health Services are always paid as a Network Benefit (paid the same whether you are in or out of the Network). That means that if you seek Emergency care at a non-Network facility, you are not required to meet the Annual Deductible or to pay any difference between Eligible Expenses and the amount the provider bills.	

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 to get Network Benefits.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract to

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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 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 receive 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, Network 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.

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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, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Plan.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible for Network 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.

When you receive Covered Health Services through a Network Physician, the Plan Administrator will pay Network Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from 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.

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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, Covered Health Services will be paid as Non-Network Benefits.

Non-Network Benefits

Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits are payable for Covered Health Services which are provided by non-Network providers.

Depending on the geographic area and the service you receive, you may have access through the Claim's Administrator's Shared Savings Program to providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, and if your Copayment is expressed as a percentage of Eligible Expenses for Non-Network Benefits, that percentage will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers than from other non-Network providers, because the Eligible Expense may be a lesser amount.

Notification Requirement

You must notify the Claims Administrator before getting certain Covered Health Services from non-Network providers. The details are shown in the *Must You Notify the Claims Administrator?* column in (Section 1: What's Covered--Benefits). If you fail to notify the Claims Administrator, Benefits are reduced or denied.

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Prior notification does not mean Benefits are payable in all cases. Coverage depends on the Covered Health Services that are actually given, your eligibility status, and any benefit limitations.

Care CoordinationSM

When you notify the Claims Administrator as described above, they will work to implement the Care 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.

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.

Network 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 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, Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

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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

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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 exclusions 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. Network 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.

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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 refer 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 eligible 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.

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

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.

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 are 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 meeting the Annual Deductible and 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, you are responsible for requesting payment from us through the Claims Administrator. You must file the claim in a

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format that contains all of the information required, as described below.

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 us, 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.
- D. An itemized bill from your provider that includes the following:

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- 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.

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

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

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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 Claims

Pre-service claims are those claims that require notification or approval prior to receiving medical care. If your claim was a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 days of receipt of the claim. If you filed a pre-service claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days after the pre-service claim was received. If additional information is needed to process the pre-service claim, the Claims Administrator will notify you of the information needed within 15 days after the claim was received, 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, 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 claim will be denied. A denial notice will explain the reason for denial, refer to the part of

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the Plan on which the denial is based, and provide the claim appeal procedures.

Urgent Claims that Require Immediate Action

Urgent claims are those claims 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 claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

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.

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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.

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 claim 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 claim 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 claim and decided according to post-service or pre-service timeframes, whichever applies.

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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

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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 Claim 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 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.

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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 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 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 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by us 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 level appeal will be conducted and you will be notified by us of the

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decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent claims, see "Urgent Claim 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 us as the Plan Administrator. Your second level appeal request must be submitted to us 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 Claim 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 Claims Administrator of your request for review of the determination taking into account the seriousness of your condition.

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For urgent claim 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.

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Section 7: When Coverage Ends

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

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

General Information about When Coverage Ends

The Plan Sponsor 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 Sponsor will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, the Plan Sponsor 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.

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

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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 Sponsor is responsible for notifying you that your coverage has ended.
You Are No Longer Eligible	Your coverage ends on the date 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 date the Claims Administrator receives written notice from us 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 happen, 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 us 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 Sponsor 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 us 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.

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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.

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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.

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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.

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Riders, Amendments, Notices

Outpatient Prescription Drug Rider

Choice Plus

**Outpatient
Prescription Drug Rider**

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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.

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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

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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 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 failed to verify your eligibility when the Prescription Drug Product was

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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, they 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, including those drugs that you purchase prior to meeting your Annual Drug Deductible. The Claims Administrator does not pass these rebates on to you, nor are they applied to your Annual Drug Deductible or taken into account in determining your Copayments.

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

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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.

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

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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 accordance with our approved guidelines, is each of the following:

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

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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.

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.

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What You Must Pay

You are responsible for paying the Annual Drug Deductible.

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.
- The Annual Drug Deductible.
- 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 our contracted rates (our Prescription Drug Cost) will not be available to you.

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Payment Information

Payment Term	Description	Amounts
Annual Drug Deductible	The amount you pay for covered Prescription Drug Products at a retail or home delivery pharmacy in a calendar year before the Plan Administrator begins paying for Prescription Drug Products.	<i>Retail and Home Delivery Pharmacy</i> \$75 per Covered Person per calendar year.
Coinsurance	<p>Your Coinsurance 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 Coinsurance 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 Coinsurance 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 Coinsurance or • The Prescription Drug Cost for that Prescription Drug Product. <p><i>See the Coinsurances stated in the Benefit Information table for amounts.</i></p>

Payment Term	Description	Amounts
Out-of-Pocket Drug Maximum	The maximum amount you are required to pay for covered Prescription Drug Products in a single calendar year. Once you reach the Out-of-Pocket Drug Maximum, you will not be required to pay any Coinsurance for covered Prescription Drug Products for the remainder of the calendar year.	\$2,500 Combined Retail and Mail Order Out-of-Pocket Maximum per individual.

Benefit Information

Description of Pharmacy Type and Supply Limits

Your Coinsurance 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 Coinsurance for each cycle supplied.

Your Coinsurance 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% of the Prescription Drug Cost, but not less than \$10 per Prescription Order or Refill for a **Tier-1 Prescription Drug Product**.

25% of the Prescription Drug Cost, but not less than \$25 per Prescription Order or Refill for a **Tier-2 Prescription Drug Product**.

40% of the Prescription Drug Cost, but not less than \$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 Refill for a 90-day supply, with refills when appropriate. You will be charged a home delivery Coinsurance 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.

Your Coinsurance 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.

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

10% of the Prescription Drug Cost, but not less than \$10 per Prescription Order or Refill for a **Tier-1 Prescription Drug Product**.

25% of the Prescription Drug Cost, but not less than \$25 per Prescription Order or Refill for a **Tier-2 Prescription Drug Product**.

40% of the Prescription Drug Cost, but not less than \$40 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. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
3. Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.
4. 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.
5. 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.
6. Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment

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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.

7. Any product dispensed for the purpose of appetite suppression and other weight loss products.
8. 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.
9. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
10. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
11. Unit dose packaging of Prescription Drug Products.
12. Medications used for cosmetic purposes.
13. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that are determined to not be a Covered Health Service.
14. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
15. Prescription Drug Products when prescribed to treat infertility.
16. Prescription Drug Products for smoking cessation.
17. Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.

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18. 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.
19. 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.
20. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

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