

City of Dallas

Health Benefits Plan Options *a Preferred Provider Organization (PPO)*

Standard and Optional PPO Plans

January 1, 2003

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Health Benefits Plan

Notice to Employees

This document establishes the City of Dallas Health Benefits Plan as of January 1, 2003.

The City of Dallas Health Benefits Plan may be changed at any time.

All benefits becoming due under the Plan are funded by City of Dallas (called "the Employer").

City of Dallas has entered into an arrangement with United HealthCare Insurance Company (called "the Company") which provides for the Company to process benefit claims and provide certain other services under the Plan.

United HealthCare Insurance Company does not insure the benefits described in this booklet.

Schedule of Benefits

Effective Date of this Plan

January 1, 2003

Medical Benefits - Active/Retiree

	Standard PPO Plan	Optional PPO Plan
Maximum Benefits		
Lifetime Maximum Benefit	\$2,000,000	\$2,000,000
Deductibles and Out-of-Pocket Maximums		
Individual Deductible (In-Network)	\$300	\$1,000
Family Deductible (In-Network)	\$900	\$3,000
Individual Deductible (Out-Network)	\$600	\$2,000
Family Deductible (Out-Network)	\$1,800	\$6,000
Non-Notification Penalty (Applicable only if Care Coordination is not notified as required. It does not count toward the Out-of-Pocket Feature.)	\$250/Procedure and/or admission	\$250/Procedure and/or admission
Non-Network Hospital Confinement Deductible (It does not count toward the Out-of-Pocket Feature.)	\$250/Procedure and/or admission	\$250/Procedure and/or admission
Individual Out-of-Pocket Maximum (In-Network)	\$2,800	\$3,500
Family Out-of-Pocket Maximum (In-Network)	\$5,400	\$7,500
Individual Out-of-Pocket Maximum (Out-Network)	\$5,600	\$7,000
Family Out-of-Pocket Maximum (Out-Network)	\$11,800	\$16,000
Copayment		
Emergency Room Copayment	\$50 per Emergency visit	\$50 per Emergency visit

Percentage of Covered Expenses Payable After Deductibles/Copayments are Satisfied		
	Network	Non-Network
Office Visits (Including Preventive Health Care)	80%	60%
Physician's Services (except office visit)	80%	60%
Physician's Services	80%	60%
Hospital Services	80%	60%
Ambulatory Surgical Center Services	80%	60%
Durable Medical Equipment (Lifetime Maximum of \$50,000)	80%	60%
Home Health Care Provider Services (including home IV therapy)	80%	60%
Hospice Care Provider Services	80%	60%
Physical Therapist Services	80%	60%
Rehabilitation Facility Services	80%	60%
Skilled Nursing Facility Confinement Services	80%	60%
All Other Covered Expenses for Medical Benefits	80%	60%

Benefits for Organ/Tissue Transplants performed at a Designated Transplant Facility are payable at 100% of Covered Expenses without application of deductibles.

Mental Health Benefits

Maximum Benefits each Calendar Year	
Inpatient (except for certain serious mental illnesses)	30 days/calendar year
Outpatient (except for certain serious mental illnesses)	20 visits/calendar year
Inpatient serious mental illness	45 days/calendar year
Outpatient serious mental illness	60 visits/calendar year

Mental Health Benefits are subject to the same Cash Deductibles and Percentages as **Medical Benefits**. There is no Out-of-Pocket Maximum applicable to **Mental Health Benefits**.

Mental Health Benefits for inpatient chemical dependency treatment are payable for only three confinements per lifetime. A confinement may follow another within one month. These two confinements will be considered as one. The Calendar Year and Lifetime Maximums shown above for **Mental Health Benefits** do not apply to chemical dependency benefits.

Pregnancy Benefits

Pregnancy Benefits are payable in the same manner as **Medical Benefits**.

Preventive Health Care Benefits

Preventive Health Care Benefits are payable in the same manner as **Medical Benefits**.

Eligibility

Eligible Employee

- Permanent Employees of the Employer, as defined in Section 34-8 of the City of Dallas Personnel Rules
- Retired Employees of the Employer, as defined under the Retired Employee Coverage section of this document
- Employees and Retired Employees must reside in the United States

Eligible Dependents

Dependents are:

- A wife or husband of an eligible Employee.
- Any unmarried child from birth through age 18 of an eligible employee.
- An unmarried child under age 25 of an eligible Employee, if the child is a registered student in regular full-time attendance at school. The child must be mainly dependent on the Employee for care and support. The child cannot be employed on a regular full-time basis by one or more employers for a total of 30 or more hours per week.
- **Child** includes the following:
 - A stepchild who resides in the eligible Employee's home.
 - A legally adopted child. (A child is considered legally adopted on the earlier of the date of placement or the date the legal adoption proceedings have been started.)
 - Any Other child related to an eligible Employee, mainly dependent on the eligible Employee for the care and support and residing in the eligible Employee's home.

Certain children may be included as Eligible Dependents under this Plan regardless of age. The child must have been covered under the Plan provided by the Employer prior to the effective date of this Plan. The child must meet the following conditions:

- The child is mentally or physically incapacitated;
- The child is not capable of self-support, and
- The child depends mainly on the Employee for support.

The Employee must give the Company proof the child meets these conditions when requested.

Eligible Others

The Mayor and members of the City Council

Cost of Coverage

The coverage under this Plan is contributory. This means that Employees must make contributions toward the cost of coverage.

Enrollment Requirements

Enrollment Date

The date the person is enrolled under this Plan.

Employee Coverage

An Employee enrolls for Employee coverage by:

- Electronic means or any other methods provided by the Employer or
- Completing an enrollment form and giving the form to the Employer

An Employee's enrollment is either timely or late.

An Employee is considered a timely enrollee if he or she enrolls during the Initial Eligibility Period, a Special Enrollment Period or during the Annual Enrollment.

Dependent Coverage

An Employee must enroll for coverage as an Employee in order to enroll his or her Dependents. If a husband and wife are both eligible Employees, only one may enroll their Dependents for coverage.

No person can be covered both as an Employee and as a Dependent.

Initial Dependents are those family members who are eligible Dependents on the date the Employee first becomes eligible for Employee coverage.

Subsequent Dependents are any family members who become Eligible Dependents after the date the Employee first becomes eligible under this Plan. Subsequent Dependents may be added during a Special Enrollment Period.

A Dependent's enrollment is either timely or late.

A Dependent is considered a timely enrollee when he or she is enrolled for coverage during the Initial Eligibility Period, a Special Enrollment Period or during the Annual Enrollment.

Enrollment Periods

The Initial Eligibility Period is the 31-day period which begins on the date of hire of the Employee or the date a Dependent first becomes a Dependent under this Plan.

Employees and/or Dependents who are not enrolled during the Initial Eligibility Period or a Special Enrollment Period must wait until the next Annual Enrollment Period to enroll for coverage, unless otherwise provided in this Plan.

The Annual Enrollment Period is designated by the Employer each year. It is held before the start of each Plan Year. During this period, all Eligible Employees and Dependents may enroll for coverage.

Special Circumstances

Special Enrollment Periods are available to certain persons who have lost other coverage and to certain dependents.

A Special Enrollment Period is available to a person who meets each of the following conditions:

- The Employee or Dependents were covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to, or was subsequently discontinued by, the Employee or Dependent.
- The Employee stated in writing, at the time coverage was previously offered or subsequently discontinued, that the other coverage was the reason for declining enrollment under this Plan. The Employer must have requested the statement at that time. The Employer must have provided the Employee with notice of this requirement (and its consequences) at that time.
- The Employee's or Dependent's prior coverage was one of the following:
 - COBRA continuation which was exhausted.
 - Non-COBRA coverage which was terminated either as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated.
- The Employee requests enrollment under this Plan not later than 31 days after the date of the end of the COBRA continuation, termination of coverage, or termination of employer contribution.

A Special Enrollment Period is available to Subsequent Dependents. The Enrollment Period is the 31-day period which begins with the date the person becomes a Dependent.

If a Subsequent Dependent is enrolled, the Employee must enroll at the same time if not already covered. In addition, any of the Employee's other Dependents may be enrolled at the same time, if not already covered, subject to the same enrollment requirements.

Late Enrollees

Except as otherwise provided in this Plan, a late enrollee can enroll only during an Annual Enrollment Period. A late enrollee is also subject to the Preexisting Condition Exclusion.

Effective Date of Employee Coverage

Employee coverage is effective on the latest of:

- The Effective Date shown in Schedule of Benefits, or
- The Employee's date of hire, provided the Employee has enrolled within his Initial Eligibility Period, or
- If later, the date the Employee enrolls for coverage.

Effective Date of Dependent Coverage

Coverage for Initial Dependents is effective on the later of:

- The date the Employee becomes covered.
- The date the Employee enrolls the Dependents.

Coverage for a Subsequent Dependent is effective as follows:

- For a spouse, the later of the date the spouse is enrolled and the date of the marriage;
- For a newborn, the date of birth; or
- For an adopted child, the date of adoption or placement for adoption.
- For any other child, the date the child becomes a Dependent.

Qualified Medical Child Support Order

If an Employee is required by a qualified medical child support order, as defined in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), to provide coverage for his/her children, these children must be enrolled at the same time as required by OBRA 93.

If the Employee is not already enrolled, the Employee may also enroll as a timely enrollee at the same time.

Special Provision for Newborn Children

Plan Benefits are payable for a newborn child for 31 days after the child's birth, even if the Employee has not enrolled the child.

If additional contributions are required from the Employee for the coverage of that child, the Employee must enroll the child during the 31-day Special Enrollment Period in order for the child to be a timely enrollee.

Selection of No Coverage During Annual Enrollment

Employees are given the option of selecting no coverage for the following calendar year during the Annual Enrollment period. An Employee selecting no coverage has effectively waived all coverages, offered by the Employer, for the Employee and any dependents for the next calendar year, except as otherwise provided in this Plan.

An Employee who during the Annual Enrollment period has selected no coverage for the following calendar year may not reenroll in any health plan offered by the Employer until the next succeeding Annual Enrollment period, except as otherwise provided in the Plan.

Retired Employee Coverage

Retired Employees are eligible for the benefits as described below after they cease being an Active Employee.

As a Retired Employee, Benefits under this Plan are continued. The continued coverage will be the same coverage as for Active Employees, except as described below

The continued benefits for Medicare Eligibles are modified as shown in **Effect of Medicare and Government Plans**.

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;
- If carried as a Dependent child, the person remains a Dependent of the surviving spouse, but only if the spouse is receiving monthly survivor's benefits from one of the retirement funds.

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

A Retired Employee, or a surviving spouse or Dependent who is eligible for Medicare participation by reason of age or disability or any other reason, must enroll in Medicare A and B in order to retain eligibility in the Plan.

If a Retired Employee is enrolled in this Plan on January 1, 2003 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.

Definitions

Retired Employee

Retired Employee means an Eligible Employee who meets all of the following:

- The Employee receives retirement pension benefits payments from the Employees' Retirement Fund of the City of Dallas ("ERF"), or the Dallas Police and Fire Pension System ("DPFP"), or elects to defer the pension benefit payment to a Deferred Retirement Option Plan ("DROP") account established by DPFP;

And

- The Employee was covered under this Plan or a continuation of this Plan (COBRA) on the day before the date of retirement.

Retired Employee also means:

- A former Employee who was within two years of reaching pension eligibility and was terminated through Reduction in Force ("RIF") as defined under the City of Dallas Civil Service rules;

Or

- A former Employee who had earned 30 years' pension service credit but did not have sufficient age to qualify as a retiree;

And (in either of the above)

- Was covered under this Plan on the day before the "RIF" or termination, who subsequently becomes eligible, because of age, to receive retirement benefits from the Employees' Retirement Fund of the City of Dallas ("ERF") or the Dallas Police and Fire Pension System ("DPFP"), or elects to defer the pension benefit payment to a Deferred Retirement Option Plan ("DROP") account established by DPFP.

Care Coordination

Covered Services and Supplies under this Plan are subject to Care Coordination.

Care Coordination determines whether the services or supplies are Covered Health Services. No benefits are payable unless Care Coordination determines the Covered Services and Supplies are covered under the Plan.

The Care Coordination program is designed to encourage an efficient system of care for Employees and Employees' enrolled Dependents by identifying and addressing possible unmet covered health care needs. This may include admission counseling, inpatient care advocacy, and certain discharge planning and disease management activities. The Care Coordination activities are not a substitute for the medical judgement of your Physician, however, and the ultimate decision as to what medical care Employees or their Dependents actually receive must be made by the Employee and their Physician.

Care Coordination is triggered when the Company receives notification of an upcoming treatment or service. The notification process serves as a gateway to Care Coordination activities and is an opportunity for the

Employee to let the Company know that they are planning to receive specific health care services. The services requiring notification include:

Inpatient

- Hospital confinement.
- Skilled Nursing Facility confinement.

Outpatient

- Back surgery.
- Ear, nose and throat surgery.
- Female pelvic surgery.
- Foot surgery.
- Gall bladder surgery.
- Hand/wrist surgery.
- Heart surgery.
- Knee surgery.
- Rectal surgery.
- Home Health Care.
- Private Duty Nursing.
- Durable Medical Equipment over \$300.
- Organ/Tissue Transplants.

The Company may be contacted by calling the phone number listed on the Employee's Health Plan ID card.

The Employee can expect to receive phone calls from the Company when certain treatments are involved.

The ultimate decisions on medical care must be made by the Covered Person and his or her Physician. Care Coordination only determines if the listed service or supply is a Covered Health Service according to the Plan benefits and provisions.

Approval by Care Coordination does not guarantee that benefits are payable under this Plan. Benefits are based on:

- The Covered Services and Supplies actually performed or given.
- The Covered Person's eligibility under this Plan on the date the Covered Services and Supplies are performed or given.
- Copayments, Deductibles, coinsurance, maximum limits, preexisting condition exclusion and all other terms of this Plan.

Notification

Care Coordination must be notified for any of the services shown in the Care Coordination Section.

How To Notify Care Coordination

Care Coordination is notified by calling the toll-free number shown on the Health Plan ID card.

When to Notify Care Coordination

- For inpatient confinement, the Covered Person must notify Care Coordination of the scheduled admission date at least 5 working days before the start of the confinement. An admission date may not have been set when the confinement was planned. The Covered Person must call Care Coordination again as soon as the admission date is set.
- Pregnancy is subject to the following notification time periods:
 - Prenatal Programs — Care Coordination should be notified during the first trimester (12 weeks) of pregnancy. This early notification makes it possible for the mother to participate in the prenatal program.
 - Inpatient Confinement for Delivery of Child — Care Coordination must be notified only if the inpatient care for the mother or child is expected to continue beyond:
 - 48 hours following a normal vaginal delivery, or
 - 96 hours following a cesarean section.

For inpatient care (for either the mother or child) which continues beyond the 48/96 hour limits stated above, Care Coordination must be notified before the end of these time periods.

- Non-Emergency Inpatient Confinement Without Delivery of Child — Confinement during pregnancy but before the admission for delivery, which is not Emergency Care, requires notification as a scheduled confinement. Care Coordination must be notified prior to the scheduled admission.
- For outpatient services which require notification, the Covered Person must notify Care Coordination at least five working days before the service is given.
- Organ/Tissue Transplants
A Covered Person must notify Care Coordination at least seven working days before the scheduled date of any of the following or as soon as reasonably possible:
 - The evaluation.
 - The donor search.
 - The organ procurement/tissue harvest.
 - The transplant.

Care Coordination will then complete a Review. The Covered Person, the Physician and the facility will be sent a letter confirming the results of the Review.

Benefits Reduced if Care Coordination Not Called

Benefits are reduced if the Covered Person does not call Care Coordination as required. This reduction is called a Non-Notification Penalty. A Non-Notification Penalty applies to each confinement, surgical procedure, or treatment plan.

The amount of the Non-Notification Penalty is shown in the **Schedule of Benefits**. The amount of the Non-Notification Penalty will never be more than the amount of the Covered Expenses.

A Covered Person can appeal a decision by calling Care Coordination.

If the Covered Person or the Physician does not agree with Care Coordination's decision, it can be appealed.

- The Covered Person or the Physician can request Care Coordination to reconsider the decision by writing or telephoning within 60 days of the decision.
- If the Covered Person, the Physician and Care Coordination still cannot find an acceptable solution, this decision can be reappealed. Another Physician will review the facts of the case — taking into account the Covered Person's and the attending Physician's point of view — and make a final decision. If the Covered

Person or the Physician do not agree with Care Coordination's review decision, a Covered Person may request that the Employer review the decision.

Emergency Care

When Emergency Care is required and results in a confinement, the Covered Person (or that person's representative or Physician) must call Care Coordination within 48 hours of the date the confinement begins.

A working day is a business day of the Company. It does not include Saturday, Sunday or a State or Federal holiday. If it is not reasonably possible to call Care Coordination within 48 hours, Care Coordination must be notified as soon as reasonably possible.

When the Emergency Care has ended, however, Care Coordination must be called before any additional services that require notification are received.

Benefits are subject to the Non-Notification Penalty if Care Coordination is not called as shown above. The Non-Notification Deductible applies to each confinement.

The amount of the Non-Notification Penalty is shown in the **Schedule of Benefits**. The amount of the Non-Notification Penalty will never be more than the amount of the Covered Expenses.

Mental Disorder Treatment

Notification Requirement

The Covered Person must call Behavioral Health Care Management (BHCM) before Covered Services and Supplies are given on an inpatient basis for Mental Disorder Treatment. This includes Hospital or Treatment Center confinement. The call starts the Review process.

BHCM can be contacted by calling the toll-free number in the directory of providers, or by calling Customer Service at the toll-free number shown on the ID card.

Benefits under this Plan are subject to the Non-Notification Penalty if BHCM is not called before services are received.

The amount of the Non-Notification Penalty is shown in the **Schedule of Benefits**. The amount of the Non-Notification Penalty will never be more than the amount of the Covered Expenses.

BHCM performs a Review to determine the Medical Necessity of Covered Services and Supplies. No benefits are payable unless BHCM determines the Covered Services and Supplies are Medically Necessary.

Emergency Care

When Emergency Care is required for Mental Disorder Treatment, the Covered Person (or representative or Physician) must call BHCM within 48 hours after the Emergency Care is given. **BHCM is ready to take calls 7 days a week, 24 hours a day**. If it is not reasonably possible to make this call within 48 hours, the call must be made as soon as reasonably possible.

When the Emergency Care has ended, BHCM must be called before any additional services are received.

Benefits are subject to the Non-Notification Penalty if BHCM is not called as required above.

The amount of the Non-Notification Penalty is shown in the **Schedule of Benefits**. The amount of the Non-Notification Penalty will never be more than the amount of the Covered Expenses.

Appeal

The Covered Person can appeal a Review. Call BHCM for further information.

Health Benefits Plan Options PPO

This Plan pays for Covered Services and Supplies received from either Network or Non-Network Providers.

If Network Providers are used, this Plan pays a greater portion of Covered Expenses. This is called the Network level.

If Non-Network Providers are used, this Plan pays a lesser portion of Covered Expenses. This is called the Non-Network level.

A directory of the Network Providers is available from the Employer.

There are many types of providers who participate in the Network. The following types of providers participate in the Network:

- Ambulatory Surgical Centers.
- Chiropractors.
- Durable Medical Equipment Providers.
- Home Health Care Providers.
- Home IV Providers.
- Hospices.
- Hospitals.
- Physical Therapists.
- Physicians.
- Podiatrists.
- Rehabilitation Facilities.
- Skilled Nursing Facilities.

This Plan also covers Specialized Providers and Specialized Facilities. These are types of providers which are not represented in the Network. These providers and facilities are not subject to the Network/Non-Network level of coverage. Instead these types of providers are covered at 80%.

Network Benefits

This Plan pays the Network percentage for Network Provider services as shown in the **Schedule of Benefits**. See **Medical Benefits** for a complete description of any deductibles or copayments that may apply under this Plan.

Non-Network Providers Paid At Network Level

- Radiology, anesthesiology, and pathology services are paid at the Network level. Services must be given in one of the settings shown below:
 - Inpatient Hospital.

- Outpatient facility which is part of a Hospital.
- Ambulatory Surgical Center.
- Emergency Care.

Emergency Care is payable at the Network level, even if services are received from a Non-Network Provider.

Network Provider Charges Not Covered

A Network Provider has contracted with the Company to participate in the Network. Under this contract a Network Provider may not charge the Covered Person or the Company for certain expenses, except as stated below. A Network Provider cannot charge the Covered Person or the Company for any services or supplies which are not Covered Health Services.

The Covered Person may agree with the Network Provider to pay any charges for services and supplies which are not Covered Health Services. In this case, the Network Provider may make charges to the Covered Person. However, these charges are not Covered Expenses under this Plan and are not payable by the Company.

Non-Network Benefits

This Plan pays the Non-Network percentage of Covered Expenses as shown in the **Schedule of Benefits** for Non-Network Provider services.

See **Medical Benefits** for a complete description of the deductibles that apply under this Plan.

Medical Benefits

Medical Benefits are payable for Covered Expenses incurred by the Covered Person while covered under this Plan.

Covered Expenses are the actual cost to the Covered Person of the Reasonable Charge for Covered Services and Supplies listed in this Benefit. The Company, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- The methodologies in the most recent edition of the Current Procedural Terminology.
- The methodologies as reported by generally recognized professionals or publications.

The Covered Expenses must be incurred for the care of an accidental injury or Sickness. A Covered Expense is incurred on the date that the Covered Service or Supply is performed or given.

Each Covered Person must satisfy certain Copayments and/or Deductibles before any payment is made for certain Covered Services and Supplies. Then the Medical Benefits pays the percentage of Covered Expenses shown in the **Schedule of Benefits**.

There is a Lifetime Maximum shown in **Schedule of Benefits**.

Covered Services and Supplies for pregnancy are shown in **Pregnancy Benefits**.

Covered Services and Supplies for Mental Disorder Treatment are shown in **Mental Health Benefits**.

Copayments and Deductibles

Before Medical Benefits are payable, each Covered Person must satisfy certain Copayments and/or Deductibles.

A Copayment is the amount of Covered Expenses the Covered Person must pay to a Network Provider at the time services are given. Copayments are not counted toward any Deductible or Out-of-Pocket Feature. Covered Services and Supplies which require a Copayment are not subject to a Deductible.

A Deductible is the amount of Covered Expenses the Covered Person must pay before Medical Benefits are payable. After the Deductible has been met, Covered Expenses are payable at the percentage shown in the **Schedule of Benefits**.

The amount of each Copayment/Deductible is shown in the **Schedule of Benefits**. A Covered Expense can only be used to satisfy one Copayment or Deductible.

Emergency Room Copayment

The Emergency Room Copayment applies to Hospital emergency room services. It applies to each emergency room visit. Emergency room services are payable only if it is determined that the services are Medically Necessary and there is not a less intensive or more appropriate place of service, diagnostic or treatment alternative that could have been used in lieu of emergency room services. (See definition of Emergency Care.)

The Emergency Room Copayment does not apply if the Covered Person is admitted as a Hospital inpatient.

Network Individual Deductible

The Network Individual Deductible applies to Covered Expenses charged by a Network Provider . It applies each Calendar Year.

Network Family Deductible

The most a whole family will have to pay for Network Individual Deductibles in any Calendar Year, no matter how large a family may be, is the amount of the Network Family Deductible. Only Covered Expenses which count toward a Covered Person's Network Individual Deductible count toward this Deductible.

Non-Network Individual Deductible

The Non-Network Individual Deductible applies to Covered Expenses charged by a Non-Network Provider. It applies each Calendar Year.

Non-Network Family Deductible

The most a family will have to pay for Non-Network Individual Deductibles in any Calendar Year, no matter how large a family may be, is the amount of the Non-Network Family Deductible. Only Covered Expenses which count toward the Covered Person's Non-Network Individual Deductible count toward this Deductible.

Cross Application of Deductibles

Any Covered Expenses used to satisfy all or part of the Network Individual Deductible and the Network Family Deductible may be used to satisfy the same portion of the Non-Network Individual and Family Deductibles. In

relation, any Covered Expenses used to satisfy the Non-Network Individual Deductible and the Non-Network Family Deductible may be used to satisfy the same portion of the Network Individual and Family Deductibles.

Non-Notification Penalty

The Non-Notification Penalty applies to Covered Expenses if Care Coordination is not notified as required.

Non-Network Hospital Confinement Deductible

The Non-Network Hospital Confinement Deductible applies to inpatient Non-Network Hospital Services.

It applies to each confinement. It does not apply to a newborn child for a Hospital confinement which begins at birth. It does not apply to confinements resulting from Emergency Care.

Out-of-Pocket Feature

Covered Expenses are payable at the percentage shown in the **Schedule of Benefits** until any Out-of-Pocket Maximum shown in the **Schedule of Benefits** has been reached during a Calendar Year. Then, Covered Expenses are payable at 100% for the rest of that year as shown below.

All Covered Expenses that the Covered Person pays, other than those shown below, count toward the Out-of-Pocket Maximums.

Covered Expenses used to satisfy the following Copayments and/or Deductibles do not count toward any of the Out-of-Pocket Maximums. These Copayments and Deductibles still apply even after the applicable Out-of-Pocket Maximum has been reached:

- Emergency Room Copayment
- Non-Notification Penalty
- Non-Network Hospital Confinement Deductible.

Network Individual Out-of-Pocket Maximum

When the Network Individual Out-of-Pocket Maximum is reached for any one Covered Person in a Calendar Year, Network Covered Expenses, other than those shown in the Out-of-Pocket Feature, are payable at 100% for that same person for the rest of that year.

Network Family Out-of-Pocket Maximum

When the Network Family Out-of-Pocket Maximum is reached for all Covered Family Members in a Calendar Year, Network Covered Expenses, other than those shown in the Out-of-Pocket Feature, are payable at 100% for all Covered Family Members for the rest of that year.

Non-Network Individual Out-of-Pocket Maximum

When the Non-Network Individual Out-of-Pocket Maximum is reached for any one Covered Person in a Calendar Year, Non-Network Covered Expenses, other than those shown in the Out-of-Pocket Feature, are payable at 100% for that person for the rest of that year.

Non-Network Family Out-of-Pocket Maximum

When the Non-Network Family Out-of-Pocket Maximum is reached for all Covered Family members in a Calendar Year, Non-Network Covered Expenses other than those shown in the Out-of-Pocket Feature, are payable at 100% for all Covered Family Members for the rest of that year.

Cross Application of Out-of-Pocket Maximums

Any Covered Expenses used to satisfy all or part of the Network Individual Out-of-Pocket Maximum and the Network Family Out-of-Pocket Maximum may be used to satisfy the same portion of the Non-Network Individual and Family Out-of-Pocket Maximums. In relation, any Covered Expenses used to satisfy the Non-Network Individual Out-of-Pocket Maximum and the Non-Network Family Out-of-Pocket Maximum may be used to satisfy the same portion of the Network Individual and Family Out-of-Pocket Maximums.

Maximum Benefit

The Maximum Benefit payable for each Covered Person is shown in the **Schedule of Benefits**. This maximum applies to each Covered Person's lifetime.

Covered Services and Supplies

Covered Services and Supplies must be Covered Health Services and given for the diagnosis or treatment of an accidental injury or Sickness.

A Covered Person and his or her Physician decide which services and supplies are given, but this Plan only pays for the following Covered Services and Supplies which are Covered Health Services as determined by the Company.

Covered Services and Supplies also include services and supplies that are part of an Alternate Care Proposal (ACP). An ACP is a course of treatment developed by the Company and authorized by the Employer as an alternative to the services and supplies that would otherwise have been considered Covered Services and Supplies.

Unless the ACP specifies otherwise, the provisions of the Plan related to benefit amounts, maximum amounts, copayments and deductibles will apply to these services.

Acupuncture Services

Must be performed by a licensed Physician.

Ambulatory Surgical Center Services

A Center's services given within 72 hours before or after a surgical procedure. The services must be given in connection with the procedure.

Anesthetics

Chemotherapy

Dialysis Treatment

Durable Medical Equipment

Durable Medical Equipment means equipment which meets all of the following:

- It is for repeated use and is not a consumable or disposable item.
- It is used primarily for a medical purpose.
- It is appropriate for use in the home.

Some examples of Durable Medical Equipment are:

- Appliances which replace a lost body organ or part or help an impaired one to work.
- Orthotic devices such as arm, leg, neck and back braces.
- Hospital-type beds.
- Equipment needed to increase mobility, such as a wheelchair.
- Respirators or other equipment for the use of oxygen.
- Monitoring devices.

The Company decides whether to cover the purchase or rental of the equipment.

Foot orthotics are not covered.

Payment for all Durable Medical Equipment and artificial aids is subject to a Lifetime Maximum of \$50,000 for each Covered Person.

Foot Care

Care and treatment of the feet, if needed due to severe systemic disease. Routine care such as removal of warts, corns, or calluses, the cutting and trimming of toenails, foot care for flat feet, fallen arches, and chronic foot strain is a Covered Service only if needed due to severe systemic disease.

Home Health Care

The following Covered Services must be given by a Home Health Care Agency:

- Temporary or part-time nursing care by or supervised by a registered graduate nurse (R.N.).
- Temporary or part-time care by a home health aide.
- Physical therapy.
- Occupational therapy.
- Speech Therapy.

Covered Services are limited to 40 visits each Calendar Year. Each period of home health aide care of up to four hours given in the same day counts as one visit. Each visit by any other member of the home health team will count as a separate visit.

Hospice Care

- Room and Board.
- Other Services and Supplies.
- Part-time nursing care by or supervised by a registered graduate nurse (R.N.).
- Home Health Care Services as shown under Home Health Care. The limit on the number of visits shown under Home Health Care does not apply to Hospice patients.
- Counseling for the patient and Covered Family Members.
- Bereavement counseling for Covered Family Members. Services must be given within six months after the patient's death. Covered Services are limited to a total of 15 visits for each family.

Counseling must be given by a Licensed Counselor.

Services for the patient must be given in an inpatient Hospice facility or in the patient's home.

The Physician must certify that the patient is terminally ill with six months or less to live.

Any counseling services given in connection with a terminal illness will not be considered as Mental Disorder Treatment.

Hospital Services

- Room and Board.
Covered Expenses for a private room are limited to the regular daily charge made by the Hospital for a semi-private room.
- Intensive Care Unit (ICU), Cardiac Care Unit (CCU), Pediatric Intensive Care Unit (PICU) and Surgical Intensive Care Unit (SICU).
- Blood and plasma.
- Other Services and Supplies.
- Emergency Room.

Emergency room services are covered only if it is determined that the services are Covered Health Services and there is not a less intensive or more appropriate place of service, diagnostic or treatment alternative that could have been used in lieu of emergency room services. If the Company, at its discretion, determines that a less intensive or more appropriate treatment could have been given then no benefits are payable.

Infertility Treatment

Diagnosis and treatment of infertility, including surgery and drug therapy, administered by a physician, as otherwise provided by this Plan.

Laboratory Tests and X-rays

X-rays or tests for diagnosis or treatment.

Medical Supplies

- Surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure.
- Blood or blood derivatives only if not donated or replaced.

Medical Transportation Services

Transportation by professional ambulance to and from a medical facility.

Transportation by regularly-scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment.

These services must be given within the United States, Puerto Rico or Canada.

Nurse-Practitioner Services

Services of a licensed or certified Nurse-Practitioner acting within the scope of that license or certification.

Oral Surgery and Dental Services

- Oral surgery if needed as a necessary, but incidental, part of a larger service in treatment of an underlying medical condition.
- The following services and supplies are covered only if needed because of accidental injury to natural teeth:
 - Oral surgery.
 - Full or partial dentures.
 - Fixed bridge work.
 - Prompt repair to natural teeth.
 - Crowns.

Organ/Tissue Transplants

Care Coordination must be notified at least seven working days before the scheduled date of any of the following or as soon as reasonably possible:

- The evaluation.
- The donor search.
- The organ procurement/tissue harvest.
- The transplant procedure.

Services and supplies for necessary organ or tissue transplants are payable under this Plan.

Donor Charges for Organ/Tissue Transplants

- In the case of an organ or tissue transplant, donor charges are considered Covered Expenses ONLY if the recipient is a Covered Person under this Plan. If the recipient is not a Covered Person, no benefits are payable for donor charges.
- The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a Covered Service UNLESS the search is made in connection with a transplant procedure arranged by a Designated Transplant Facility.

If a Qualified Procedure, listed below, is a Covered Health Service and performed at a Designated Transplant Facility, the **Medical Care and Treatment** and **Transportation and Lodging** provisions described below apply.

Qualified Procedures

- Heart Transplants.
- Lung transplants.
- Heart/Lung transplants.
- Liver transplants.
- Kidney transplants.
- Pancreas transplants.
- Kidney/Pancreas transplants.
- Bone Marrow/Stem Cell transplants.
- Other transplant procedures when the Company determines that it is necessary to perform the procedure at a Designated Transplant Facility.

Medical Care and Treatment

The Covered Expenses for services provided in connection with the transplant procedure include:

- Pre-transplant evaluation for one of the procedures listed above.
- Organ acquisition and procurement.
- Hospital and physician fees.
- Transplant procedures.
- Follow-up care for a period up to one year after the transplant.
- Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for bone marrow/stem cell search, a Maximum Benefit of \$25,000 is payable for all charges made in connection with the search.

Transportation and Lodging

Care Coordination will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

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

- Reasonable and necessary 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 \$50 for one person or up to \$100 for two people.
- Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Designated Transplant Facility.
- If the patient is a covered dependent minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the \$100 per diem rate.
- There is a combined overall lifetime maximum 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.

Orthoptic Training (Eye Muscle Exercise)

Training by a licensed optometrist or an orthoptic technician. Covered Services are limited to a lifetime maximum of 20 visits for each Employee or Dependent spouse. Covered Services are limited to a lifetime maximum of 30 visits for each Dependent child.

Outpatient Occupational Therapy

Services of a licensed occupational therapist, provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician. The therapist must submit progress reports at the intervals stated in the treatment plan.
- The therapy must be expected to result in significant, objective, measurable physical improvement in the Covered Person's condition within 2 months of the start of the treatment.

Covered Services are limited to 20 visits each Calendar Year.

Outpatient Physical Therapy

Services of a licensed physical therapist, provided the following conditions are met:

- The therapy must be ordered and monitored by a Physician.
- The therapy must be given in accordance with a written treatment plan approved by a Physician. The therapist must submit progress reports at the intervals stated in the treatment plan.
- The therapy must be expected to result in significant, objective, measurable physical improvement in the Covered Person's condition within 2 months of the start of the treatment.

Covered Services are limited to 20 visits each Calendar Year. Covered Services are limited to three types of treatment to each body part during each visit.

Physician Services

Medical Care and Treatment

- Hospital, office and home visits.
- Emergency room services.

Surgery

Services for surgical procedures.

Reconstructive Surgery

- Reconstructive surgery to improve the function of a body part when the malfunction is the direct result of one of the following:
 - Birth defect.
 - Sickness.
 - Surgery to treat a Sickness or accidental injury.
 - Accidental injury.
- Reconstructive breast surgery following a necessary mastectomy.
- Reconstructive surgery to remove scar tissue on the neck, face, or head if the scar tissue is due to Sickness or accidental injury.
- Cosmetic procedures are excluded from coverage. Procedures that correct a 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.

Notify Care Coordination for benefits 5 business days before receiving services. By notifying Care Coordination, Care Coordination can verify that the service is a reconstructive procedure rather than a cosmetic one.

Assistant Surgeon Services

Covered Expenses for assistant surgeon services are limited to 1/5 of the amount of Covered Expenses for the surgeon's charge for the surgery. An assistant surgeon must be a Physician. Surgical assistant's services are not covered.

Multiple Surgical Procedures

Multiple surgical procedures means more than one surgical procedure performed during the same operative session. Covered Expenses for multiple surgical procedures are limited as follows:

- Covered Expenses for a secondary procedure are limited to 50% of the Covered Expenses that would otherwise be considered for the secondary procedure had it been performed during a separate operative session.
- Covered Expenses for any subsequent procedure are limited to 25% of the Covered Expenses that would otherwise be considered for the subsequent procedure had it been performed during a separate operative session.

Prescribed Drugs and Medicines

Prescribed drugs and medicines for inpatient services.

Private Duty Nursing Care

Private duty nursing care given on an outpatient basis by a licensed nurse (R.N., L.P.N., or L.V.N.).

Payment for outpatient private duty nursing care is subject to a Lifetime Maximum of \$50,000 for each Covered Person.

Psychologist Services

Radiation Therapy

Rehabilitation Therapy

Inpatient

- Services of a Hospital or Rehabilitation Facility for room, board, care and treatment during a confinement.
- Inpatient rehabilitative therapy is a Covered Service only if intensive and multidisciplinary rehabilitation care is necessary to improve the patient's ability to function independently.

Covered Services are limited to a combined total of 120 days of confinement in a Hospital, Skilled Nursing Facility and/or Rehabilitation Facility each Calendar Year.

Outpatient

- Services of a Hospital or Comprehensive Outpatient Rehabilitative Facility (CORF).
- Covered Services are limited to 20 days of therapy each Calendar Year. A day of therapy includes all services given by or visits to the Hospital or CORF in any one day.
- Covered Services for each day of therapy reduces the number of visits under Covered Services for Outpatient Physical Therapy, Outpatient Occupational Therapy or Speech Therapy. This reduction only applies to days of therapy during which the therapy includes services given by a physical therapist, occupational therapist or speech therapist.

Skilled Nursing Facility Services

- Room and Board.

Covered Expenses for Room and Board are limited to the facility's regular daily charge for a semi-private room.

- Other Services and Supplies.

Covered Services are limited to the first 120 days of confinement each Calendar Year.

Speech Therapy

Services of a licensed speech therapist.

These services must be given to restore speech lost or impaired due to one of the following:

- Surgery, radiation therapy or other treatment which affects the vocal cords.
- Cerebral thrombosis (cerebral vascular accident).
- Brain damage due to accidental injury or organic brain lesion (aphasia).
- Accidental injury.

The therapy must be expected to result in significant, objective, measurable physical improvement in the Covered Person's condition within 2 months of the start of the treatment.

Covered Services are limited to 20 visits each Calendar Year.

Speech Therapy for Children Under Age 3

Services of a licensed speech therapist for treatment given to a child under age 3 whose speech is impaired due to one of the following conditions:

- Infantile autism.
- Developmental delay or cerebral palsy.
- Hearing impairment.
- Major congenital anomalies that affect speech such as, but not limited to, cleft lip and cleft palate.

Covered Services are limited to 20 visits each Calendar Year.

Spinal Manipulations

Services of a Physician given for the detection or correction (manipulation) by manual or mechanical means of structural imbalance or distortion in the spine.

Covered Services are limited to 20 visits each Calendar Year.

Temporomandibular Joint Dysfunction (TMJ) Services

Benefits for diagnostic or surgical treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) when provided by or under the direction of a Physician. Benefits include diagnostic or surgical treatment required as a result of accident, trauma, congenital defect, developmental defect or pathology.

Benefits are not provided for any dental service. Dental splints are excluded.

Voluntary Sterilization

- Vasectomy.
- Tubal ligation.

Exclusions and limitations that apply to this benefit are in General Exclusions and Limitations.

Mental Health Benefits

Benefits are payable for Covered Services and Supplies for Mental Disorder Treatment given to the Covered Person while covered under this Plan. These Covered Services and Supplies are listed in **Medical Benefits**.

These Mental Health Benefits are subject to the same deductibles and percentage of Covered Expenses payable as benefits that are paid due to Sickness, except as shown below.

Mental Health Benefits include, but are not limited to:

- Assessment.
- Diagnosis.
- Treatment planning.
- Medication management.
- Individual, family and group psychotherapy.

- Psychological education.
- Psychological testing.

Serious Mental Illness means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

- Schizophrenia
- Paranoid and other psychotic disorders
- Bipolar disorders (hypomanic, manic, depressive and mixed)
- Major depressive disorders (single episode or recurrent)
- Schizo-affective disorders (bipolar or depressive)
- Pervasive developmental disorders
- Obsessive-compulsive disorders
- Depression in childhood and adolescence

Covered Services and Supplies for Mental Disorder Treatment are subject to the following limitations:

Maximum Benefits each Calendar Year	
Inpatient except for certain serious mental illnesses	30 days/calendar year
Outpatient except for certain serious mental illnesses	20 visits/calendar year
Inpatient serious mental illness	45 days/calendar year
Outpatient serious mental illness	60 visits/calendar year

The Out-of-Pocket Feature shown in **Medical Benefits** does not apply to Mental Health Benefits. Covered Expenses incurred for Mental Disorder Treatment do not count toward the Out-of-Pocket Maximums. After the Out-of-Pocket Maximums are reached, benefits for Mental Disorder Treatment are not payable at 100%. Serious Mental Illness is covered the same as any other illness.

Additional Covered Services and Supplies specific to Mental Disorder Treatment are listed below. These Additional Covered Services and Supplies are subject to the same requirements as Covered Services and Supplies listed in **Medical Benefits**.

Additional Covered Services and Supplies

Licensed Counselor Services

Services of a Licensed Counselor for Mental Disorder Treatment.

Treatment Center Services

- Room and Board.
- Other Services and Supplies.

Exclusions and limitations that apply to this benefit are in General Exclusions and Limitations.

Pregnancy Benefits

For Employees and Dependent Spouses Only

Benefits are payable for Covered Services and Supplies for pregnancy given to the Covered Person while covered under this Plan. These Covered Services and Supplies are listed in **Medical Benefits**.

Benefits for pregnancy are paid in the same way as benefits are paid for Sickness.

Benefits are payable for at least:

- 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.

The hospital or other provider is not required to get authorization from the Company for the time periods stated above. Authorizations are required for longer lengths of stay.

Federal law does not prohibit the mother's or newborn's attending Physician, after consulting with the mother, from discharging the mother or her newborn child earlier than 48 hours (or 96 hours, as applicable).

Additional Covered Services and Supplies specific to pregnancy are listed below. These Additional Covered Services and Supplies are subject to the same requirements as Covered Services and Supplies listed in **Medical Benefits**.

Additional Covered Services and Supplies

Birth Center Services

- Room and Board.
- Other Services and Supplies.
- Anesthetics.

Nurse-Midwife's Services

Services of a licensed or certified Nurse-Midwife.

Routine Well Baby Care

The following services and supplies given during a newborn child's initial Hospital confinement:

- Hospital services for nursery care.
- Other Services and Supplies given by the Hospital.
- Services of a surgeon for circumcision.
- Physician Services.

For Dependent Children Only

Pregnancy Benefits for Dependent Children are limited to Covered Services and Supplies for Complications of Pregnancy.

Benefits are payable for Covered Services and Supplies for the treatment of Complications of Pregnancy given to a Dependent Child while covered under this Plan. These Covered Services and Supplies are listed in **Medical Benefits**.

Benefits for Complications of Pregnancy are paid in the same way as benefits are paid for Sickness.

Benefits for Complications of Pregnancy which result in the delivery of a child are payable for at least:

- 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.

The hospital or other provider is not required to get authorization from the Company for the time periods stated above. Authorizations are required for longer lengths of stay.

Definition of Complications of Pregnancy

A condition that requires medical treatment before or after pregnancy ends. The following conditions are considered Complications of Pregnancy:

- Acute nephritis.
- Nephrosis.
- Cardiac decompensation.
- Missed abortion.
- Disease of any of the following body systems:
 - Vascular.
 - Hemopoietic.
 - Nervous.
 - Endocrine.
- Other medical or surgical conditions as severe as those listed above.
- Pernicious vomiting (Hyperemesis gravidarum).
- Toxemia (Pre-eclampsia).
- Cesarean section.
- Ectopic pregnancy which is ended.
- A natural loss of the fetus during the first 20 weeks of pregnancy.

The following are not considered Complications of Pregnancy:

- 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.

Not Covered

As to the Covered Person's Dependent Children, services and supplies for pregnancy other than Complications of Pregnancy.

Any expenses incurred in connection with an abortion chosen by the Covered Person.

Exclusions and limitations that apply to these benefits are in General Exclusions and Limitations.

Family Planning Benefits

Benefits are payable for Covered Expenses for Family Planning Benefits incurred by the Covered Person while covered under this Plan.

Covered Expenses are the actual cost to the Covered Person of the Reasonable Charge for the Covered Services and Supplies listed in this Benefit. A Covered Expense is incurred on the date that the Covered Service or Supply is performed or given.

These Family Planning Benefits are subject to the same copayments, deductibles and percentage of Covered Expenses payable as benefits that are paid due to Sickness under **Medical Benefits**.

After coverage under this Plan stops, there are no extended benefits.

Covered Services and Supplies

Services and devices, including but not limited to: Intrauterine device and related Physician services.

- Physician services related to a diaphragm fitting.
- Voluntary sterilization by either vasectomy or tubal ligation.
- Surgical implants for contraception, such as Norplant.

Charges for oral contraceptives are covered under Prescription Drug Benefits-

Assisted Reproductive Technology

Covered Services and Supplies for Assisted Reproductive Technology (ART) are limited to a Covered Person who has undergone extensive screening and has been selected for ART because the Company has determined, in its discretion, that for that person:

- The ART is safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications.
- There is not a less intensive or more appropriate diagnostic or treatment alternative that could have been used in lieu of the following assisted reproductive technology procedures:

Benefits are available for in-vitro fertilization, with the exception of :

- More than three attempts at in-vitro during any calendar year.
- Gamete intrafallopian transfer (GIFT)
- Zygote intrafallopian transfer (ZIFT)
- Microinjection techniques.
- Artificial Insemination.

Covered Person must have been unable to become pregnant through more conservative means for a minimum of 12 months, unless one partner has already been diagnosed as infertile.

Not Covered

- More than three attempts at ART.

- ART if infertility is the result of voluntary sterilization.
- Assisted reproductive technology services for persons who are clinically deemed to be high risk if pregnancy occurs, or who have no reasonable expectation of becoming pregnant.

Exclusions and limitations that apply to these benefits are in General Exclusions and Limitations.

Prescription Medication

Benefits are provided under a separate plan (Prescription Drug Program) for prescription drugs other than compounded prescriptions that are (i) not in the formulary of the prescription drug provider; (ii) medically necessary; and (iii) safe, effective and approved for the treatment of the diagnosed condition by either the FDA or the Program medical review process.

Preventive Health Care Benefits

Benefits are payable for Covered Services and Supplies for Preventive Health Care Benefits when given to a Covered Person by either a Network Physician or Non-Network Physician. However, the Plan pays a greater portion of the Covered Expense if the person receives the services from a Network Physician.

The Covered Person must be covered under this Plan on the date the Covered Service or Supply is performed or given.

Benefits are payable at the Network level as shown in **Schedule of Benefits** if Covered Services and Supplies are received from a Network Physician.

Benefits are payable at the Non-Network level as shown in **Schedule of Benefits** if Covered Services and Supplies are received from a Non-Network Physician.

After coverage under this Plan stops, there are no extended benefits.

Covered Services and Supplies

- Routine physical exam for covered Employees and Dependent spouses, including diagnostic tests and immunizations. Routine hearing exam and screening is covered.
- Child preventive care services given in connection with routine pediatric care, including PKU tests and immunizations.
- Routine rectal exam and prostate specific antigen (PSA) test or other approved prostate cancer test on all male participants age thirty-five (35) and over.
- Routine well-woman exams. A well-woman exam includes the following:
 - Breast examination and/or mammogram.
 - Pelvic examination.
 - Pap smear.
- Chromosome testing.

Exclusions and limitations that apply to these benefits are in General Exclusions and Limitations.

General Exclusions and Limitations

This Plan does not include coverage for a person covered as both an Employee and as a Dependent under the same Plan.

This Plan does not cover any expenses incurred for services, supplies, medical care or treatment relating to, arising out of, or given in connection with, the following:

- Services or supplies received before an Employee or his or her Dependent becomes covered under this Plan.
- Abdominoplasty.
- Breast reduction surgery.
- Chelation therapy, except to treat heavy metal poisoning.
- Completion of claim forms, or missed appointments.
- Cosmetic or reconstructive surgery or treatment. (This is surgery or treatment primarily to change appearance), regardless whether or not it is for psychological or emotional reasons. See **Medical Benefits** for limited coverage of reconstructive surgery.
- Custodial Care. This is care consisting of services and supplies that meets one of the following conditions:
 - Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment.
 - Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional.

Care that meets one of these conditions is custodial care regardless of any of the following:

- Who recommends, provides or directs the care.
- Where the care is provided.
- Whether or not the patient or another caregiver can be or is being trained to care for himself or herself.
- Ecological or environmental medicine, diagnosis and/or treatment.
- Education, training and bed and board while confined in an institution which is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home.
- Eye glasses, contact lenses, eye refractions, hearing aids and cochlear implants, unless required due to an accidental injury or cataract surgery.
- Herbal medicine, holistic or homeopathic care, including drugs.
- Services, supplies, medical care or treatment given by one of the following members of the Employee's immediate family:
 - The Employee's spouse.
 - The child, brother, sister, parent or grandparent of either the Employee or the Employee's spouse.
- Charges for procedures such as, artificial insemination, gamete intrafallopian transfer, zygote intrafallopian transfer and tubal ovum transfer.
- Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time United HealthCare Insurance Company makes a determination regarding coverage in a particular case are determined to be:
 - not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service, or the United States Pharmacopoeia Dispensing Information, as appropriate for the proposed use; or
 - subject to review and approval by any institutional review board for the proposed use; or

- the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- a service that does not meet the definition of a Covered Health Services.

If a Covered Person has a “life-threatening” Sickness or condition (one which is likely to cause death within one year of the request for treatment) the Company may determine that an Experimental, Investigational or Unproven Service meets the definition of a Covered Health Service for the Sickness or condition. For this to take place, the Company must determine that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

- Services and supplies which the Covered Person is not legally required to pay.
- Liposuction.
- Surgical correction or other treatment of malocclusion.
- Services or supplies which are not Covered Health Services, including any confinement or treatment given in connection with a service or supply which is not covered under the Plan.
- Membership costs for health clubs, weight loss clinics and similar programs.
- Nutritional counseling, other than as provided for the treatment of diabetes.
- Occupational injury or Sickness. An occupational injury or Sickness is an injury or Sickness which is covered under a workers' compensation act or similar law.
- Examinations or treatment ordered by a court in connection with legal proceedings unless such examinations or treatment otherwise qualify as Covered Services.
- Services given by a pastoral counselor.
- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs.
- Private duty nursing services while confined in a facility.
- Services for a surgical procedure to correct refraction errors of the eye, including any confinement, treatment, services, or supplies given in connection with or related to the surgery.
- Services for, or related to, the removal of an organ or tissue from a person for transplantation into another person, unless the transplant recipient is a Covered Person under this Plan and is undergoing a covered transplant.
- Reversal of sterilization.
- Sensitivity training, educational training therapy except for the treatment of diabetes or treatment for an education requirement.
- Sex-change surgery.
- Charges made by a Hospital for confinement in a special area of the Hospital which provides non-acute care, by whatever name called, including but not limited to the type of care given by the facilities listed below.

If that type of facility is otherwise covered under this Plan, then benefits for that covered facility which is part of a Hospital, as defined, are payable at the coverage level for that facility, not at the coverage level for a Hospital.

- Adult or child day care center.
- Ambulatory Surgical Center.
- Birth Center.
- Half-way house.
- Hospice.
- Skilled Nursing Facility.

- Treatment Center.
- Vocational rehabilitation center.
- Any other area of a Hospital which renders services on an inpatient basis for other than acute care of sick, injured or pregnant persons.
- Stand-by services required by a Physician.
- Care of or treatment to the teeth, gums or supporting structures such as, but not limited to, periodontal treatment, endodontic services, extractions, implants or any treatment to improve the ability to chew or speak. See **Medical Benefits** for limited coverage of oral surgery and dental services.
- Tobacco dependency.
- Services or supplies received as a result of war declared or undeclared, or international armed conflict.
- Weight reduction or control (unless there is a diagnosis of morbid obesity).
- Special foods, food supplements, liquid diets, diet plans or any related products.
- Wigs or toupees (except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury), hair transplants, hair weaving or any drug if such drug is used in connection with baldness.
- Services given by volunteers or persons who do not normally charge for their services.

Preexisting Condition Exclusion

A preexisting condition is an injury or Sickness which was diagnosed or treated or for which prescription medications or drugs were prescribed or taken within the six- month period ending on the person's Enrollment Date. A preexisting condition does not include pregnancy. Genetic information is not an indicator of a preexisting condition if there is not a diagnosis of a condition related to the genetic information.

Continuous Creditable Coverage. Continuous creditable coverage is health care coverage under any of the types of plans listed below, during which there was a lapse in coverage of no more than 62 days.

- A group health plan.
- Health insurance coverage.
- Medicare.
- Medicaid.
- Medical and dental care for members and certain former members of the uniformed services and their dependents.
- The Federal Employees Health Benefits Program.
- A medical care program of the Indian Health Services or of a tribal organization.
- A state health benefits risk pool.
- A health benefit plan under the Peace Corps Act.
- Any public health benefit program provided by a state, county or other political subdivision of a state.

A Covered Person can show the Employer the length of Continuous Creditable Coverage in order to either shorten or eliminate the time period during which the preexisting condition exclusion applies. Any or all of the plans that provided prior coverage must give the Covered Person a certificate of creditable coverage. If necessary, the Employer will help in obtaining this certificate of creditable coverage from a prior plan.

No coverage is provided for the treatment of a preexisting condition until the earlier of the following:

- the date the person has had Continuous Creditable Coverage for a period of six months and has not received treatment for the preexisting condition; or
- the date the person has had Continuous Creditable Coverage for twelve months.

EXCEPTION: This exclusion does not apply to newborn children or newly adopted children. 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.

Claims Information

How to File a Claim

A claim form does not need to be filed when a Network Provider is used.

The following steps should be completed when submitting bills for payment:

- Get a claim form from the Employer or the Company.
- Complete the Employee portion of the form.
- Have the provider complete the provider portion of the form.
- Send the form and bills to the address shown on the form.

Make sure the bills and the form include the following information:

- The Employee's name and social security number.
- The Employer's name and contract number (227059).
- The patient's name.
- The diagnosis.
- The date the services or supplies were incurred.
- The specific services or supplies provided.

If the Covered Employee asks for a claim form but does not receive it within 15 days, the covered Employee can file a claim without it by sending the bills with a letter, including all of the information listed above.

When Claims Must be Filed

The covered Employee must give the Company written proof of loss within 12 months after the date the expenses are incurred.

The Company will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested.

No benefits are payable for claims submitted after the 12 month period, unless it can be shown that:

- It was not reasonably possible to submit the claim during the 12 month period, and
- Written proof of loss was given to the Company as soon as was reasonably possible.

How and When Claims Are Paid

All payments will be paid to the covered Employee as soon as the Company receives satisfactory proof of loss, except in the following cases:

- If the covered Employee has financial responsibility under a court order for a dependent's medical care, the Company will make payments directly to the provider of care.
- If the Company pays benefits directly to Network Providers.
- If the covered Employee requests in writing that payments be made directly to a provider. A covered Employee does this when completing the claim form.

These payments will satisfy the Company's obligation to the extent of the payment.

The Company will send an Explanation of Benefits (EOB) to the covered Employee. The EOB will explain how the Company considered each of the charges submitted for payment. If any claims are denied or denied in part, the covered Employee will receive a written explanation.

Any benefits continued for Dependents after a covered Employee's death will be paid to one of the following:

- The surviving spouse.
- A Dependent child who is not a minor, if there is no surviving spouse.
- A provider of care who makes charges to the covered Employee's Dependents for Covered Services and Supplies.
- The legal guardian of the covered Employee's Dependent.

Legal Actions

The covered Employee may not sue on a claim before 60 days after proof of loss has been given to the Company. The covered Employee may not sue after three years from the time proof of loss is required, unless the law in the area where the covered Employee lives allows for a longer period of time.

Review Procedure for Denied Claims

In cases where a claim for benefits payment is denied in whole or in part, the claimant may appeal the denial. A request for review must be directed to the Company within 60 days after the claim payment date or the date of the notification of denial of benefits. When requesting a review, the claimant should state the reason he or she believes the claim was improperly paid or denied and submit any data or comments to support the claim.

A review of the denial will be made and the Company will provide the claimant with a written response within 60 days of the date the Company receives the claimant's request for review. If, because of extenuating circumstances, the Company is unable to complete the review process within 60 days, the Company will notify the claimant of the delay within the 60 day period and will provide a final written response to the request for review within 120 days of the date the Company received the claimant's written request for review.

If the denial is upheld, the Company's written response to the claimant will cite the specific Plan provision(s) upon which the denial is based.

If the Company continues to deny a claim after this review, a Covered Person may request that the Employer review the claim. The request must be in writing to the Employer and must be made within 60 days after the date the Covered Person receives the notice from the Company that the Company has denied the claim on review.

Coordination of Benefits

Coordination of benefits applies when a covered Employee or a covered Dependent have health coverage under this Plan and one or more Other Plans.

One of the plans involved will pay the benefits first: that plan is Primary. Other Plans will pay benefits next: those plans are Secondary. The rules shown in this provision determine which plan is Primary and which plan is Secondary.

Whenever there is more than one plan, the total amount of benefits paid in a Calendar Year under all plans cannot be more than the Allowable Expenses charged for that Calendar Year.

Definitions

"Other Plans" are any of the following types of plans which provide health benefits or services for medical care or treatment:

- Group policies or plans, whether insured or self-insured. This does not include school accident-type coverage.
- Group coverage through HMOs and other prepayment, group practice and individual practice plans.
- Group-type plans obtained and maintained only because of membership in or connection with a particular organization or group.
- Government or tax supported programs. This does not include Medicare or Medicaid.

"Primary Plan": A plan that is Primary will pay benefits first. Benefits under that plan will not be reduced due to benefits payable under Other Plans.

"Secondary Plan": Benefits under a plan that is Secondary may be reduced due to benefits payable under Other Plans that are Primary.

"Allowable Expenses" means the necessary, reasonable and customary expense for health care when the expense is covered in whole or in part under at least one of the plans.

The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense unless the patient's stay in a private Hospital room is necessary either in terms of generally accepted medical practice, or as defined in the plan.

When a plan provides benefits in the form of services, instead of a cash payment, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

How Coordination Works

When this Plan is Primary, it pays its benefits as if the Secondary Plan or Plans did not exist.

When this Plan is a Secondary Plan, its benefits are reduced so that the total benefits paid or provided by all plans during a Calendar Year are not more than total Allowable Expenses. The amount by which this Plan's benefits have been reduced shall be used by this Plan to pay Allowable Expenses not otherwise paid, which were incurred during the Calendar Year by the person for whom the claim is made. As each claim is submitted, this Plan determines its obligation to pay for Allowable Expenses based on all claims which were submitted up to that point in time during the Calendar Year.

The benefits of this Plan will only be reduced when the sum of the benefits that would be payable for the Allowable Expenses under the Other Plans, in the absence of provisions with a purpose like that of this

Coordination of Benefits provision, whether or not claim is made, exceeds those Allowable Expenses in a Calendar Year.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Which Plan Pays First

When two or more plans provide benefits for the same Covered Person, the benefit payment will follow the following rules in this order:

- A plan with no coordination provision will pay its benefits before a plan that has a coordination provision.
- The benefits of the plan which covers the person other than as a dependent are determined before those of the plan which covers the person as a dependent.
- The benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent, if the person is also a Medicare beneficiary and both of the following are true:
 - Medicare is secondary to the plan covering the person as a dependent.
 - Medicare is primary to the plan covering the person as other than a dependent (example, a retired employee).
- When this Plan and another plan cover the same child as a dependent of parents who are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year. This is called the "Birthday Rule." The year of birth is ignored.

If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

If the other plan does not have a birthday rule, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

- If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - First, the plan of the parent with custody for the child.
 - Second, the plan of the spouse of the parent with the custody of the child.
 - Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This rule does not apply with respect to any claim for which any benefits are actually paid or provided before the entity has that actual knowledge.

- If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules that apply to dependents of parents who are not separated or divorced.
- The benefits of a plan which covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same rule applies if a person is a dependent of a person covered as a retiree or an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
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If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber for the longer period are determined before those of the plan which covered that person for the shorter period.

Right to Exchange Information

In order to coordinate benefit payments, the Company needs certain information. It may get needed facts from or give them to any other organization or person. The Company need not tell, or get the consent of, any person to do this, subject to any requirements of applicable law.

A Covered Person must give the Company the information it asks for about other plans. If the Covered Person cannot furnish all the information the Company needs, the Company has the right to get this information from any source. If any other organization or person needs information to apply its coordination provision, the Company has the right to give that organization or person such information. Information can be given or obtained without the consent of any person to do this, subject to any requirements of applicable law.

Facility of Payment

It is possible for benefits to be paid first under the wrong plan. The Company may pay the plan or organization or person for the amount of benefits that the Company determines it should have paid. That amount will be treated as if it was paid under this Plan. The Employer or Plan will not have to pay that amount again.

Right of Recovery

The Company may pay benefits that should be paid by another plan or organization or person. The Employer or Plan may recover the amount paid from the other plan or organization or person.

Benefits may be paid that are in excess of what should have been paid under this Plan. The Employer or Plan has the right to recover the excess payment.

Recovery Provisions

Refund of Overpayments

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

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment made under this Plan exceeded the benefits under this Plan.

The refund equals the amount of benefits paid in excess of the amount that should have been paid under this Plan.

If the refund is due from another person or organization, the Covered Person agrees to help the Employer get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Plan may reduce the amount of any future benefits that are payable under this Plan. The Plan may also reduce future benefits under any other group benefits plan administered by the Company for the

Employer. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

Reimbursement of Benefits Paid

If benefits are paid under this Plan for expenses incurred on account of a Covered Person, the Employee or any other person or organization that was paid must make a refund to the Plan if that person or organization recovers funds from a source other than this Plan as a result of claims against any other party for negligence, wrongful acts or omissions. The refund equals the amount of the recovery or payment, up to the amount paid under this Plan.

If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Plan may reduce the amount of any future benefits that are payable under this Plan. The Plan may also reduce future benefits under any other group benefits plan administered by the Company for the Employer. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

Subrogation

In the event a Covered Person suffers an injury or Sickness as a result of an allegedly negligent or wrongful act or omission of a third party, the Plan has the right to pursue subrogation against any person or insurer.

The Plan will be subrogated and succeed to the Covered Person's right of recovery against any person or insurer. The Plan may use this right to the extent of the benefits under this Plan.

The Covered Person agrees to help the Plan use this right when requested.

Effect of Medicare and Government Plans

Medicare

When a Covered Person becomes eligible for Medicare, this Plan pays its benefits in accordance with the Medicare Secondary Payer requirements of federal law. If the Employer is subject to the Medicare Secondary Payer requirements, this Plan will pay primary.

When This Plan Pays Primary to Medicare

This Plan pays primary to Medicare for Covered Persons who are Medicare eligible if:

- Eligibility for Medicare is due to age 65 and the employee has "current employment status" with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to disability and the employee has "current employment status" with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to end stage renal disease (ESRD) under the conditions and for the time periods specified by federal law.

When Medicare Pays Primary to this Plan

Medicare pays primary to this Plan for Covered Persons who are Medicare eligible if:

- The employee is a Retired Employee.
- Eligibility is due to disability and the Employee does NOT have "current employment status" with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to end stage renal disease (ESRD), but only after the conditions and/or time periods specified in federal law cause Medicare to become primary.

See **How this Plan Pays When Medicare is Primary.**

Important! - Medicare Enrollment Requirements

When this Plan pays benefits first, without regard to Medicare, and the Covered Person wants Medicare to pay after this Plan, the Covered Person must enroll for Medicare Parts A and B. If the Covered Person does not enroll for Medicare when he or she is first eligible, the Covered Person must enroll during the special enrollment period which applies to that person when the person stops being eligible under this Plan.

When Medicare pays benefits first, benefits available under Medicare are deducted from the amounts payable under this Plan, whether or not the person has enrolled for Medicare. If Medicare pays first, the Covered Person should enroll for both Parts A and B of Medicare when that Covered Person is first eligible; otherwise, the expenses may not be covered by the Plan or Medicare.

How This Plan Pays When Medicare Is Primary

If Medicare pays benefits first, this Plan pays benefits as described below. This method of payment only applies to Medicare eligibles. It does not apply to any Covered Person unless that Covered Person becomes eligible under Medicare and Medicare is the Primary payer.

First, this Plan determines the amount payable according to the benefits under the Plan. However, the amount of Covered Expenses is based on the amount of charges allowed under Medicare rules instead of the Reasonable Charges as defined by the Plan. Then, this Plan subtracts the amount payable under Medicare for the same expenses from Plan benefits. This Plan pays only the difference (if any) between Plan benefits and Medicare benefits.

The amount payable under Medicare which is subtracted from this Plan's benefits is determined as the amount that would have been payable under Medicare when Medicare is primary even if:

- The person is not enrolled for Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in a Veterans Administration facility or other facility of the federal government. Medicare benefits are determined as if the services were provided by a non-governmental facility and covered under Medicare.
- The person is enrolled under a Plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

Government Plans (other than Medicare and Medicaid)

If the Covered Person is also covered under a Government Plan, this Plan does not cover any services or supplies to the extent that those services or supplies, or benefits for them, are available to that Covered Person under the Government Plan.

This provision does not apply to any Government Plan which by law requires this Plan to pay primary.

A Government Plan is any plan, program, or coverage other than Medicare or Medicaid which is established under the laws or regulations of any government, or in which any government participates other than as an employer.

Termination of Coverage

Employee Coverage

Employee coverage ends on the day the person stops being an eligible Employee, or if later, the last day of a period for which contributions for the cost of coverage have been made.

See **Death**, **Disability** and **Leave of Absence** below.

Death

When coverage for an Employee is terminated by reason of death, his or her family (if included as Dependents under the Plan at the time of death) receives ninety days coverage paid in full by the City. At the end of the ninety day period covered family members are eligible for COBRA coverage. A surviving spouse or Dependents who are eligible for survivor retirement benefits under the Employees' Retirement Fund of the City of Dallas, or the Dallas Police and Fire Pension System, or the Deferred Retirement Option Plan may be covered under this Plan, in lieu of COBRA coverage, at their option.

Disability

The Employer has the right to continue a person's employment and coverage under this Plan during a period in which the person is away from work due to disability. The period of continuation is determined by the Employer based on the Employer's general practice for an Employee in the person's job class.

Coverage ends on the date the Employer notifies the Company that the person's employment has stopped and coverage is to be ended.

Leave of Absence

The Employer has the right to continue the person's employment and coverage under this Plan during a period in which the person is away from work due to an approved leave of absence. The period of continuation is determined by the Employer based on the Employer's general practice for an Employee in the person's job class.

Coverage will end on the earlier of:

- The last day of the month in which the leave begins.
- The last day of a period for which contributions for the cost of coverage have been made, if the contributions for the next period are not made when due.

Dependent Coverage

Coverage for all of an Employee's Dependents ends on the earlier of the following:

- The day the Employee's coverage ends.
- The last day of a period for which contributions for the cost of Dependent coverage have been made, if the contributions for the next period are not made when due.

Coverage for an individual Dependent ends on the earlier of:

- The day the Dependent (other than the wife or husband of an Employee) becomes covered as an Employee under this Plan.
- The day the Dependent stops being an eligible Dependent.

Continuation of Coverage for Incapacitated Children

A mentally or physically incapacitated child's coverage will not end due to age. It will continue as long as Dependents coverage under this Plan continues and the child continues to meet the following conditions:

- The child is incapacitated.
- The child is not capable of self-support.
- The child depends mainly on the Employee for support.

The Employee must give the Company proof that the child meets these conditions when requested. The Company will not ask for proof more than once a year.

Glossary

(These definitions apply when the following terms are used.)

Ambulatory Surgical Center

A specialized facility which is established, equipped, operated, and staffed primarily for the purpose of performing surgical procedures and which fully meets one of the following two tests:

- It is licensed as an Ambulatory Surgical Center by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located.
- Where licensing is not required, it meets all of the following requirements:
 - It is operated under the supervision of a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one Hospital in the area.
 - It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic and that the anesthesiologist or anesthetist remain present throughout the surgical procedure.
 - It provides at least one operating room and at least one post-anesthesia recovery room.
 - It is equipped to perform diagnostic X-ray and laboratory examinations or has an arrangement to obtain these services.
- It has trained personnel and necessary equipment to handle emergency situations.

- It has immediate access to a blood bank or blood supplies.
- It provides the full-time services of one or more registered graduate nurses (R.N.) for patient care in the operating rooms and in the post-anesthesia recovery room.
- It maintains an adequate medical record for each patient, the record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or X-rays, an operative report and a discharge summary.

An Ambulatory Surgical Center which is part of a Hospital, as defined herein, will be considered an Ambulatory Surgical Center for the purposes of this Plan.

Birth Center

A specialized facility which is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the following two tests:

- It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located.
- It meets all of the following requirements:
 - It is operated and equipped in accordance with any applicable state law.
 - It is equipped to perform routine diagnostic and laboratory examinations such as hematocrit and urinalysis for glucose, protein, bacteria and specific gravity.
 - It has available to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
 - It is operated under the full-time supervision of a licensed doctor of medicine (M.D.), doctor of osteopathy (D.O.) or registered graduate nurse (R.N.).
 - It maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications.
 - It maintains an adequate medical record for each patient, the record to contain prenatal history, prenatal examination, any laboratory or diagnostic tests and a postpartum summary.
 - It is expected to discharge or transfer patients within 24 hours following delivery.

A Birth Center which is part of a Hospital, as defined herein, will be considered a Birth Center for the purposes of this Plan.

Calendar Year

A period of one year beginning with a January 1.

Comprehensive Outpatient Rehabilitation Facility

A facility which is primarily engaged in providing diagnostic, therapeutic and restorative services to outpatients for the rehabilitation of injured or sick persons and which fully meets one of the following two tests:

- It is approved by Medicare as a Comprehensive Outpatient Rehabilitation Facility.
- It meets all of the following tests:
 - It provides at least the following comprehensive outpatient rehabilitation services:
 - Services of Physicians who are available at the facility on a full or part- time basis.
 - Physical therapy.

- Social or psychological services.
- It has policies established by a group of professional personnel (associated with the facility) including one or more Physicians to govern the comprehensive outpatient rehabilitation services it furnishes, and provides for the carrying out of such policies by a full or part-time Physician.
- It has a requirement that every patient must be under the care of a Physician.
- It is established and operated in accordance with the applicable licensing and other laws.

Covered Health Service(s)

Covered Health Services are those health services, supplies or equipment provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or symptoms. Covered Health Services must be provided:

- When the Plan is in effect;
- Prior to the date that any of the individual termination conditions set forth in this Summary Plan Description; and
- Only when the person who receives services is a Covered Person and meets all eligibility requirements specified in the Plan.

A Covered Health Service must meet each of the following criteria:

- It is supported by national medical standards of practice.
- It is consistent with conclusions of prevailing medical research that demonstrates that the health service has a beneficial effect on health outcomes and are based on trials that meet the following designs:
 - Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
 - Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)
- It is a cost-effective method and yields a similar or better outcome to other available alternatives.
- It is a health service or supply that is described in this section, and which is not excluded under General Exclusions.

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well- conducted randomized trials or cohort studies, as described.

Covered Family Members or Covered Person

The Employee and the Employee's wife or husband and/or Dependent children who are covered under this Plan.

Designated Transplant Facility

A facility designated by the Company to render necessary Covered Services and Supplies for Qualified Procedures under this Plan.

Emergency Care

Medical care and treatment provided after the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:

- The patient's health would be placed in serious jeopardy.
- Bodily function would be seriously impaired.
- There would be serious dysfunction of a bodily organ or part.

In addition, Emergency Care includes immediate Mental Disorder Treatment when the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Employee

A person on the payroll of the Employer and regularly employed by the Employer on a permanent or special full or part-time basis of not less than 20 hours per week. This term excludes leased employees and independent contractors.

Experimental, Investigational or Unproven Services

Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes a determination regarding coverage in a particular case are determined to be:

- not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service, or the United States Pharmacopoeia Dispensing Information, as appropriate for the proposed use; or
- subject to review and approval by any institutional review board for the proposed use; or
- the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

The Company, in its judgment, may deem an Experimental, Investigational or Unproven Service covered under this Plan for treating a life threatening sickness or condition if it is determined by the Company that the Experimental, Investigational or Unproven Service at the time of the determination:

- is proved to be safe with promising efficacy; and
- is provided in a clinically controlled research setting, and
- uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term "life threatening" is used to describe Sicknesses or conditions which are more likely than not to cause death within one year of the date of the request for treatment.)

Home Health Care Agency

An agency or organization which provides a program of home health care and which meets one of the following three tests:

- It is approved under Medicare.
- It is established and operated in accordance with the applicable licensing and other laws.
- It meets all of the following tests:
 - It has the primary purpose of providing a home health care delivery system bringing supportive services to the home.
 - It has a full-time administrator.
 - It maintains written records of services provided to the patient.
 - Its staff includes at least one registered graduate nurse (R.N.) or it has nursing care by a registered graduate nurse (R.N.) available.
 - Its employees are bonded and it maintains malpractice insurance.

Hospice

An agency that provides counseling and incidental medical services for a terminally ill individual. Room and Board may be provided. The agency must meet one of the following three tests:

- It is approved by Medicare as a Hospice.
- It is licensed in accordance with any applicable state laws.
- It meets the following criteria:
 - It provides 24 hour-a-day, 7 day-a-week service.
 - It is under the direct supervision of a duly qualified Physician.
 - It has a nurse coordinator who is a registered graduate nurse with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.
 - The main purpose of the agency is to provide Hospice services.
 - It has a full-time administrator.
 - It maintains written records of services given to the patient.
 - It maintains malpractice insurance coverage.

A Hospice which is part of a Hospital will be considered a Hospice for the purposes of this Plan.

Hospital

An institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets one of the following three tests:

- It is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations.
- It is approved by Medicare as a Hospital.

- It meets all of the following tests:
 - It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified Physicians.
 - It continuously provides on the premises 24-hour-a-day nursing service by or under the supervision of registered graduate nurses.
- It is operated continuously with organized facilities for operative surgery on the premises.

Licensed Counselor

A person who specializes in Mental Disorder Treatment and is licensed as a Licensed Professional Counselor (LPC) or Licensed Clinical Social Worker (LCSW) by the appropriate authority.

Medically Necessary or Medical Necessity

Health care services and supplies which are determined by the Company to be medically appropriate, and

- (1) necessary to meet the basic health needs of the Covered Person; and
- (2) rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the service or supply; and
- (3) consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the Company; and
- (4) consistent with the diagnosis of the condition; and
- (5) required for reasons other than the convenience of the Covered Person or his or her Physician; and
- (6) demonstrated through prevailing peer-reviewed medical literature to be either:
 - (a) safe and effective for treating or diagnosing the condition or Sickness for which their use is proposed, or,
 - (b) safe with promising efficacy
 - (i) for treating a life threatening Sickness or condition, and
 - (ii) in a clinically controlled research setting; and
 - (iii) using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term "life threatening" is used to describe Sicknesses or conditions which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, Sickness, mental illness or pregnancy does not mean that it is a Medically Necessary service or supply as defined above. The definition of Medically Necessary used in this booklet relates only to coverage and differs from the way in which a Physician engaged in the practice of medicine may define medically necessary.

Medicare

The Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act.

Mental Disorder Treatment

Mental Disorder Treatment is treatment for both of the following:

- Any Sickness which is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/ or physiological dependence or addiction to alcohol or psychiatric drugs or medications, regardless of any underlying physical or organic cause, and
- Any Sickness where the treatment is primarily the use of psychotherapy or other psychotherapist methods.

All inpatient services, including Room and Board, given by a mental health facility or area of a Hospital which provides mental health or substance abuse treatment for a Sickness identified in the DSM, are considered Mental Disorder Treatment, except in the case of multiple diagnoses.

If there are multiple diagnoses, only the treatment for the Sickness which is identified in the DSM is considered Mental Disorder Treatment.

Detoxification services given prior to and independent of a course of psychotherapy or substance abuse treatment is not considered Mental Disorder Treatment.

Prescription Drugs are not considered Mental Disorder Treatment.

Network Provider

A provider which participates in the network.

Non-Network Hospital

A Hospital (as defined) which does not participate in the network.

Non-Network Provider

A provider which does not participate in the network.

Nurse-Midwife

A person who is licensed or certified to practice as a Nurse-Midwife and fulfills both of these requirements:

- A person licensed by a board of nursing as a registered nurse.
- A person who has completed a program approved by the state for the preparation of Nurse-Midwives.

Nurse-Practitioner

A person who is licensed or certified to practice as a Nurse-Practitioner and fulfills both of these requirements:

- A person licensed by a board of nursing as a registered nurse.
- A person who has completed a program approved by the state for the preparation of Nurse-Practitioners.

Other Services and Supplies

Services and supplies furnished to the individual and required for treatment, other than the professional services of any Physician and any private duty or special nursing services (including intensive nursing care by whatever name called).

Physician

A legally qualified:

- Doctor of Medicine (M.D.).
- Doctor of Chiropody (D.P.M.; D.S.C.).
- Doctor of Chiropractic (D.C.).
- Doctor of Dental Surgery (D.D.S.).
- Doctor of Medical Dentistry (D.M.D.).
- Doctor of Osteopathy (D.O.).
- Doctor of Podiatry (D.P.M.).

Plan

The Employee's medical benefits described in this Booklet.

Pre-Admission Tests

Tests performed on a Covered Person in a Hospital before confinement as a resident inpatient provided they meet all of the following requirements:

- The tests are related to the performance of scheduled surgery.
- The tests have been ordered by a Physician after a condition requiring surgery has been diagnosed and Hospital admission for surgery has been requested by the Physician and confirmed by the Hospital.
- The Covered Person is subsequently admitted to the Hospital, or the confinement is canceled or postponed because a Hospital bed is unavailable or because there is a change in the Covered Person's condition which precludes the surgery.

Psychologist

A person who specializes in clinical psychology and fulfills one of these requirements:

- A person licensed or certified as a psychologist.
- A Member or Fellow of the American Psychological Association, if there is no government licensure or certification required.

Reasonable Charge

As to charges for services rendered by or on behalf of a Network Physician, an amount not to exceed the amount determined by the Company in accordance with the applicable fee schedule.

As to all other charges, an amount measured and determined by the Company by comparing the actual charge for the service or supply with the prevailing charges made for it. The Company determines the prevailing charge. It takes into account all pertinent factors including:

- The complexity of the service.

- The range of services provided.
- The prevailing charge level in the geographic area where the provider is located and other geographic areas having similar medical cost experience.

Rehabilitation Facility

A facility accredited as a rehabilitation facility by the Commission on Accreditation of Rehabilitation Facilities.

Review or Review Process

A review and determination that the services and supplies are Covered Health Services.

Room and Board

Room, board, general duty nursing, intensive nursing care by whatever name called, and any other services regularly furnished by the Hospital as a condition of occupancy of the class of accommodations occupied, but not including professional services of Physicians nor special nursing services rendered outside of an intensive care unit by whatever name called.

Rehabilitation Facility

A facility accredited as a rehabilitation facility by the Commission on Accreditation of Rehabilitation Facilities.

Review or Review Process

A review and determination that the services and supplies are Covered Health Services.

Room and Board

Room, board, general duty nursing, intensive nursing care by whatever name called, and any other services regularly furnished by the Hospital as a condition of occupancy of the class of accommodations occupied, but not including professional services of Physicians nor special nursing services rendered outside of an intensive care unit by whatever name called.

Serious Mental Illness

Serious mental illness means:

- Schizophrenia;
- Paranoia and other psychotic disorders;
- Bipolar disorders (hypomanic, manic, depressive and mixed);
- Major depressive disorders (single episode) or recurrent;
- Schizo-affective disorders (bipolar or depressive);
- Pervasive developmental disorders;
- Obsessive-compulsive disorders; and
- Depression in childhood or adolescence.

Sickness

The term "Sickness" used in connection with newborn children will include congenital defects and birth abnormalities, including premature births.

Skilled Nursing Facility

If the facility is approved by Medicare as a Skilled Nursing Facility then it is covered by this Plan.

If not approved by Medicare, the facility may be covered if it meets the following tests:

- It is operated under the applicable licensing and other laws.
- It is under the supervision of a licensed Physician or registered graduate nurse (R.N.) who is devoting full time to supervision.
- It is regularly engaged in providing Room and Board and continuously provides 24-hour-a-day skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an injury or Sickness.
- It maintains a daily medical record of each patient who is under the care of a licensed Physician.
- It is authorized to administer medication to patients on the order of a licensed Physician.
- It is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill.

A Skilled Nursing Facility which is part of a Hospital will be considered a Skilled Nursing Facility for the purposes of this Plan.

Specialized Facility

A facility which is a Non-Network facility and which holds a license that is not the same type held by any Network Provider.

Specialized Provider

A provider who is a Non-Network Provider but who also holds a health care professional license that is not the same type held by any Network Provider in the service area in which the services are rendered.

Treatment Center

A facility which provides a program of effective Mental Disorder Treatment and meets all of the following requirements:

- It is established and operated in accordance with any applicable state law.
- It provides a program of treatment approved by a Physician and the Company.
- It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services:
 - Room and Board (if this Plan provides inpatient benefits at a Treatment Center).
 - Evaluation and diagnosis.
 - Counseling.
 - Referral and orientation to specialized community resources.

A Treatment Center which qualifies as a Hospital is covered as a Hospital and not as a Treatment Center.

Continuation of Health Coverage (COBRA)

If coverage under this Plan would have stopped due to a Qualifying Event, a Qualified Beneficiary may elect to continue coverage subject to the provisions below.

The Qualified Beneficiary may continue only the coverage in force immediately before the Qualifying Event.

The coverage being continued will be the same as the coverage provided to similarly situated individuals to whom a Qualifying Event has not occurred.

Coverage will continue until the earliest of the following dates:

- 18 months from the date the Qualified Beneficiary's health coverage would have stopped due to a Qualifying Event based on employment stopping or work hours being reduced.
- If a Qualified Beneficiary is determined to be disabled under the Social Security Act at any time during the first 60 days of continued coverage due to the employee's employment stopping or work hours being reduced, that Qualified Beneficiary may elect an additional 11 months of coverage under this Plan, subject to the following conditions:
 - The Qualified Beneficiary must provide the Company with the Social Security Administration's determination of disability within 60 days of the time the determination is made and within the initial 18-month continuation period.
 - The Qualified Beneficiary must agree to pay any increase in the required payment necessary to continue the coverage for the additional 11 months.
 - If the Qualified Beneficiary entitled to the additional 11 months of coverage has nondisabled family members who are entitled to continuation coverage, those nondisabled family members are also entitled to the additional 11 months of continuation coverage.

- 36 months from the date the health coverage would have stopped due to the Qualifying Event other than those described above.
- For the spouse or dependent of an Employee who was entitled to Medicare prior to a qualifying event that is either the termination of employment or work hours being reduced, 18 months from the date of the qualifying event or if later, 36 months from the date of the Employee's Medicare entitlement.
- The date this Plan stops being in force.
- The date the Qualified Beneficiary fails to make the required payment for the coverage.
- The date the Qualified Beneficiary, after electing this continuation, becomes covered under Medicare or any other group health plan. (This does not apply if the other group health plan excludes or limits coverage for a Qualified Beneficiary's preexisting condition.)

If within the original 18 month continuation period, another Qualifying Event occurs, coverage can be continued for an additional period, for a total of 36 months from the date of the first Qualifying Event.

Coverage will stop for the same reasons as coverage would have stopped for the first Qualifying Event.

Election Period

A Qualified Beneficiary has at least 60 days to elect to continue coverage. The election period ends on the later of:

- 60 days after the date coverage would have stopped due to the Qualifying Event.
- 60 days after the date the person receives notice of the right to continue coverage.

Unless otherwise specified, an Employee or spouse's election to continue coverage will be considered an election on behalf of all other Qualified Beneficiaries who would also lose coverage because of the same Qualifying Event.

Required Payments

A Qualified Beneficiary has 45 days from the date of election to make the first required payment for the coverage. The first payment will include any required payment for the continued coverage before the date of the election.

Notification Requirements

A Qualified Beneficiary must notify the Company within 60 days when any of the following Qualifying Events happen:

- The Qualified Beneficiary's marriage is dissolved.
- The Qualified Beneficiary becomes legally separated from his or her spouse.
- A child stops being an eligible Dependent.

The Company will send the appropriate Election Form to the Qualified Beneficiary within 14 days after receiving this notice.

Conversion

At the end of this continuation period, a Qualified Beneficiary may be eligible for a conversion privilege if one is generally available under the plan.

Claims

File a claim by completing a medical claim form and attaching your bills to the form. "COBRA" should be written on the claim form and on each of the bills.

Special Terms that Apply to this Continuation Provision

Qualifying Event

A Qualifying Event is any of the following which results in loss of coverage for a Qualified Beneficiary:

- The Employee's employment ends.
- The Employee's work hours are reduced.
- The Employee becomes entitled to benefits under Medicare.
- The Employee's death.
- The Employee's marriage is dissolved.
- The Employee becomes legally separated from his/her spouse.
- The Employee's Dependent child stops being an eligible Dependent.

A bankruptcy is a Qualifying Event for certain Retired Employees and their Dependents under certain conditions. If there is a bankruptcy, Retired Employees should contact the Company for more information.

Qualified Beneficiary

Any of the following persons who are covered under the plan on the day before a Qualifying Event:

- The Employee.
- An Employee's spouse.
- An Employee's former spouse (or legally separated spouse).
- A Dependent child, including a child born to or placed for adoption with the Employee during a period of continued coverage.

Continuation of Health Coverage During Family and Medical Leave (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) requires Employers to provide up to a total of 12 weeks of unpaid, job-protected leave during any 12-month period to eligible Employees for certain family and medical reasons. This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. See the Employer to find out details about how this continuation applies to you.

For the duration of a FMLA leave, the Employer must maintain the Employee's health coverage. The Employee may continue the Plan benefits for himself or herself and his or her Dependents on the same terms as if the Employee had continued to work. The Employee must pay the same contributions toward the cost of the coverage that he or she made while working.

If the Employee fails to make the payments on a timely basis, the Employer, after giving you written notice, can end the coverage during the leave if payment is more than 30 days late.

- Upon return from a FMLA leave, most Employees must be restored to their original or equivalent positions with equivalent pay, benefits and other employment terms.
- The use of a FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an Employee's leave.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your Employer.

Women's Health and Cancer Rights Act Of 1998

This plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphadema). For more information, contact the Plan Administrator, UHC at 1-800-377-2442.

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