

Summary Plan Description
United HealthCare Services, Inc.

Choice Plus Plan

(89M) - Plan 7 Actives

for

Racine County

Group Number: 712930
Effective Date: January 1, 2011

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Introduction

We are pleased to provide you with this Summary Plan Description (SPD). This SPD describes your Benefits, as well as your rights and responsibilities, under the Plan.

How to Use this Document

We encourage you to read your SPD and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this SPD by reading (Section 1: What's Covered--Benefits) and (Section 2: What's Not Covered--Exclusions). You should also carefully read (Section 9: General Legal Provisions) to better understand how this SPD and your Benefits work. You should call the Claims Administrator if you have questions about the limits of the coverage available to you.

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

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

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

Information about Defined Terms

Because this SPD is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in (Section 10: Glossary of Defined Terms). You can refer to Section 10 as you read this document to have a clearer understanding of your SPD.

When we use the words "we", "us", and "our" in this document, we are referring to the Plan Sponsor. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in (Section 10: Glossary of Defined Terms).

Your Contribution to the Benefit Costs

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

Customer Service and Claims Submittal

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

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

Prior Notification: As shown on your ID card.

Mental Health/Substance Use Disorder Services

Administrator: As shown on your ID card.

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

Claims Submittal Address:

United HealthCare Services, Inc.

Attn: Claims

P. O. Box 30555

Salt Lake City, Utah 84130-0555

Requests for Review of Denied Claims and Notice of Complaints:

Name and Address For Submitting Requests:

United HealthCare Services, Inc.

P. O. Box 30432

Salt Lake City, Utah 84130-0432

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Section 1: What's Covered--Benefits

This section provides you with information about:

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

Accessing Benefits

You can choose to receive either Network Benefits or Non-Network Benefits. In most cases, you must see a Network Physician to obtain Network Benefits.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive. For details about when Network Benefits apply, see (Section 3: Description of Network and Non-Network Benefits).

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

- Covered Health Services are received while the Plan is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in (Section 8: When Coverage Ends) occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Plan.

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

Copayment

Copayment is the amount you pay each time you receive certain Covered Health Services. For a complete definition of Copayment, see (Section 10: Glossary of Defined Terms). Copayment amounts are listed on the following pages next to the description for each Covered Health Service. Please note that when Copayments are calculated as a percentage (rather than as a set dollar amount) the percentage is based on Eligible Expenses.

Eligible Expenses

Eligible Expenses for Covered Health Services, incurred while the Plan is in effect, are determined by us or by our designee. In almost all cases our designee is the Claims Administrator. For a complete definition of Eligible Expenses that describes how payment is determined, see (Section 10: Glossary of Defined Terms).

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

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

Notification Requirements

Prior notification is required before you receive certain Covered Health Services. In general, Network providers are responsible for

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

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

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

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

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

- The Cosmetic Procedures exclusion. Examples of procedures that may or may not be considered Cosmetic include: breast reduction and reconstruction (except for after cancer surgery when it is always considered a Covered Health Service); vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty.

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

Special Note Regarding Medicare

If you are enrolled for Medicare on a primary basis (Medicare pays before we pay Benefits under the Plan), the notification requirements described in this SPD do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in (Section 7: Coordination of Benefits). You are not required to notify the Claims Administrator before receiving Covered Health Services.

Special Note Regarding Mental Health and Substance Use Disorder Services

You must provide pre-service notification as described below.

When Benefits are provided for any of the services listed below, the following services require notification:

- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home.
- Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders -inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility).; intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing;

extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

For a scheduled admission, you must notify the Mental Health/Substance Use Disorder Administrator prior to the admission, or as soon as reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to notify the Mental Health/Substance Use Disorder Administrator as required benefits will be reduced by \$200.

In addition, you must notify the Mental Health/Substance Use Disorder Administrator before the following services are received. If you fail to notify the Mental Health/Substance Use Disorder Administrator as required benefits will be reduced by \$200.

Services requiring prior notification are:

- Intensive outpatient program treatment.
- Outpatient electro-convulsive treatment.
- Psychological testing.
- Outpatient treatment of opioid dependence; and
- Extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

Special Mental Health and Substance Use Disorder Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Mental Health and Substance Use Disorder Services benefits. The Mental Health and Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness or substance use disorder which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services before you are eligible to receive Benefits. The actual amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. For a complete definition of Eligible Expenses, see (Section 10: Glossary of Defined Terms).	<u>Network</u> \$200 per Covered Person per calendar year, not to exceed \$600 for all Covered Persons in a family.
		<u>Non-Network</u> \$200 per Covered Person per calendar year, not to exceed \$600 for all Covered Persons in a family.
Network and Non-Network Deductibles cross apply.		
Out-of-Pocket Maximum	The maximum you pay, out of your pocket, in a calendar year for Copayments. For a complete definition of Out-of-Pocket Maximum, see (Section 10: Glossary of Defined Terms).	<u>Network</u> \$1,000 per Covered Person per calendar year, not to exceed \$3,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible.
		<u>Non-Network</u> \$1,000 per Covered Person per calendar year, not to exceed \$3,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible.
Network and Non-Network Out-of-Pocket Maximums cross apply.		
Annual Maximum Benefit		<u>Network and Non-Network Combined</u> \$2,000,000 per Covered Person.

Payment Term	Description	Amounts
Maximum Plan Benefit	<p>There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.</p> <p>Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.</p>	<p><u><i>Network and Non-Network Combined</i></u></p> <p>No Maximum Plan Benefit.</p>

Benefit Information

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
1. Acupuncture Services	<u>Network</u>	10%	Yes	Yes
Acupuncture services covered only if provided by a Physician.	No			
	<u>Non-Network</u>	25%	Yes	Yes
	No			
2. Ambulance Services - Emergency only	<u>Network</u>	<i>Ground Transportation:</i> 10%	Yes	Yes
Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.	No	<i>Air Transportation:</i> 10%		
	<u>Non-Network</u>	<i>Ground Transportation:</i> 20%	Yes	Yes
	No	<i>Air Transportation:</i> 20%		

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>3. Autism Spectrum Disorder Services</p> <p>The following definitions apply for purposes of Autism Spectrum Disorders:</p> <p>"Autism Spectrum Disorders" means any of the following:</p> <ul style="list-style-type: none"> • Autism disorder. • Asperger's Syndrome. • Pervasive development disorder not otherwise specified. <p>"Intensive-level services" means evidence-based behavioral therapies that is designed to help an individual with autism spectrum disorder overcome the cognitive, social and behavioral deficits associated with that disorder.</p> <p>"Non-intensive-level services" means evidence-based therapy that occurs after the completion of treatment for Intensive-level services or, for an individual who has not and will not receive intensive-level services, evidence-based therapy that will improve the individual's condition.</p> <p>Intensive Level Services</p> <p>Note: Benefits for intensive-level services begin after the Enrolled Dependent child turns two years of age but prior to turning nine years of age.</p> <ul style="list-style-type: none"> • Benefits are provided for evidence-based behavioral intensive-level therapy for an insured with a verified diagnosis of autism spectrum disorder, the majority of which shall be provided to 	<p><u>Network</u> No</p>	<p>Depending upon where the Covered Health Service is provided, Benefits for outpatient <i>Autism Spectrum Disorder Treatment</i> will be the same as those stated under <i>Physician's Office Services - Sickness and Injury</i>, and Benefits for inpatient/intermediate <i>Autism Spectrum Disorder Services</i> will be the same as those stated under <i>Hospital - Inpatient Stay</i></p>		

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>the Enrolled Dependent child when the parent or legal guardian is present and engaged. The prescribed therapy must be consistent with all of the following requirements:</p> <ul style="list-style-type: none"> • Based upon a treatment plan developed by a qualified provider that includes at least 20 hours per week over a six-month period of time of evidence-based behavioral intensive therapy, treatment and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the Enrolled Dependent child be present and engaged in the intervention. • Implemented by qualified providers, qualified supervising provider, qualified professional, qualified therapists or qualified paraprofessionals. • Provided in an environment most conducive to achieving the goals of the Enrolled Dependent child's treatment plan. • Included training and consultation, participation in team meeting and active involvement of the Enrolled Dependent child's family and treatment team for implementation of the therapeutic goals developed by the team. • The Enrolled Dependent child is directly observed by the qualified provider at least once every two months. • Beginning after the Enrolled Dependent child is two years of age and before the Enrolled Dependent child is nine years of age. 				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>Intensive-level services will be covered for up to four cumulative years. We may credit against any previous intensive-level services the Enrolled Dependent child received against the required four years of intensive-level services regardless of payer. We may also require documentation including medical records and treatment plans to verify any evidence-based behavioral therapy the insured received for autism spectrum disorders that was provided to the Enrolled Dependent child prior to attaining nine years of age. Evidence-based behavioral therapy that was provided to the Enrolled Dependent child for an average of 20 or more hours per week over a continuous six-month period to be intensive-level services.</p> <p>Travel time for qualified providers, supervising providers, professionals, therapists or paraprofessionals is not included when calculating the number of hours of care provided per week. We are not required to reimburse for travel time.</p> <ul style="list-style-type: none"> We require that progress be assessed and documented throughout the course of treatment. We may request and review the Enrolled Dependent child's treatment plan and the summary of progress on a periodic basis. 				
<p>Non-Intensive Level Services</p>				
<p>Non-intensive Level Services will be covered for an Enrolled Dependent child with a verified diagnosis of autism spectrum disorder for non-intensive level services that are evidence-based and are provided to an Enrolled Dependent child by a qualified provider, professional, therapist or paraprofessional in either of the following conditions:</p>				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> • After the completion of intensive-level services and designed to sustain and maximize gains made during intensive level services treatment. • To an Enrolled Dependent child who has not and will not receive intensive-level services but for whom non-intensive level services will improve the Enrolled Dependent child's condition. <p>Benefits will be provided for evidence-based therapy that is consistent with all of the following requirements:</p>				
<ul style="list-style-type: none"> • Based upon a treatment plan developed by a qualified provider, supervising provider, professional or therapist that includes specific therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the Enrolled Dependent child be present and engaged in the intervention. • Implemented by qualified providers, qualified supervising providers, qualified professionals, qualified therapist or qualified paraprofessionals. • Provided in an environment most conducive to achieving the goal of the Enrolled Dependent child's treatment plan. • Included training and consultation, participation in team meetings and active involvement of the Enrolled Dependent child's family in order to implement the therapeutic goals developed by the team. 				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> • Provided supervision of providers, professionals, therapists and paraprofessionals by qualified supervising providers on the treatment team. <p>Non-intensive level services may include direct or consultative services when provided by qualified providers, qualified supervising providers, qualified professionals, qualified paraprofessionals, or qualified therapists.</p> <p>We require that progress be assessed and documented throughout the course of treatment. We may request and review the Enrolled Dependent child's treatment plan and the summary of progress on a periodic basis.</p> <p>Travel time for qualified providers, qualified supervising providers, qualified professional, qualified therapists or qualified paraprofessionals in not included when calculating the number of hours of care provided per week. We are not required to reimburse for travel time.</p> <ul style="list-style-type: none"> • Intensive-level and Non-intensive-level services include but are not limited to speech, occupational and behavioral therapies. <p>The following services are not covered under the autism spectrum disorder services:</p> <ul style="list-style-type: none"> • Acupuncture. • Animal-based therapy including hippotherapy. • Auditory integration training. • Chelation therapy. • Child care fees. 				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> • Cranial sacral therapy. • Custodial or respite care. • Hyperbaric oxygen therapy. • Special diets or supplements. • Pharmaceuticals and durable medical equipment. 				

Notification Requirements

Depending upon where the Covered Health Service is provided, any applicable notification or authorization requirements will be the same as those stated under each Covered Health Service category

Non-Network
No

Depending upon where the Covered Health Service is provided, Benefits for outpatient *Autism Spectrum Disorder Treatment* will be the same as those stated under *Physician's Office Services - Sickness and Injury*, and Benefits for inpatient/intermediate *Autism Spectrum Disorder Services* will be the same as those stated under *Hospital - Inpatient Stay*

4. Dental Services - Accident only

Dental services when all of the following are true:

- Treatment is necessary because of accidental damage.

Network
No

10%

Yes

Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D." The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. <p>Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities.</p>	<u>Non-Network</u> No	25%	Yes	Yes
<p>5. Dental Anesthesia Services – Hospital/Ambulatory Surgical Center</p> <p>Benefits for Hospital or Ambulatory Surgical Center charges provided in conjunction with dental care, including anesthesia provided, if any of the following apply:</p>	<u>Network</u> No	10%	Yes	Yes
<ul style="list-style-type: none"> The covered person is a child under the age of 5. The covered person has a chronic disability. The covered person has a medical condition requiring hospitalization or general anesthesia for dental care. 	<u>Non-Network</u> No	25%	Yes	Yes
<p>6. Dental Services – Oral Surgery</p> <p>Oral Surgical Procedures are limited to:</p>	<u>Network</u> No	10%	Yes	Yes
<ul style="list-style-type: none"> Surgical exposure or removal of fully or partially impacted teeth. 				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> Removal of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examinations. 				
<ul style="list-style-type: none"> Surgical procedures required to correct Accidental Injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth. The Injury must happen while You are covered under the Plan. Removal of apex of tooth root (apicoectomy). Removal of exostosis of the jaw and hard palate. External incision and drainage of cellulitis. Cutting of accessory sinuses, salivary glands or ducts. Reducing dislocations and removal of the temporomandibular joints (TMJ). Gingivectomy – Removal of loose gum tissue to end infection. Alveolectomy – Leveling structures supporting teeth for the purpose of fitting dentures. Root canal, therapy when performed with apicoectomy. Frenectomy – Incision of any mid-line fold of tissue between the jaw and lips and/or lower jaw and tongue. Removal of retained (residual) root. Gingival curettage under general anesthesia. Apical curettage. Extraction of seven or more natural teeth, at one time. 	<u>Non-Network</u> No	25%	Yes	Yes

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

7. Diabetes Treatment

Benefits include expenses incurred by the installation and use of an insulin infusion pump and diabetes self-management education programs.

Benefits are limited to one pump per calendar year.

<u>Network</u> No	10%	Yes	Yes
<u>Non-Network</u> No	25%	Yes	Yes

8. Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use.
- Used for medical purposes.
- Not consumable or disposable.
- Not of use to a person in the absence of a disease or disability.

<u>Network</u> No	10%	Yes	Yes
<u>Non-Network</u> Yes	25%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment.</p> <p>Examples of Durable Medical Equipment include:</p> <ul style="list-style-type: none"> • Equipment to assist mobility, such as a standard wheelchair. • A standard Hospital-type bed. • Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks). • Delivery pumps for tube feedings (including tubing and connectors). • Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are covered under the Plan. Dental braces are also excluded from coverage. • Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage). • If the equipment is purchased, benefits will be payable for subsequent repairs and batteries necessary to restore the equipment to a serviceable condition. If such equipment cannot be restored to a serviceable condition, replacement will be 				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>payable subject to prior approval by the Plan. Subsequent repairs due to abuse or misuse, as determined by the Plan, are not covered.</p> <ul style="list-style-type: none"> The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless Medical Necessity due to growth of the person or changes to medical condition require a different product as determined by the Plan. <p>We and Bowers & Associates will decide if the equipment should be purchased or rented.</p> <p style="text-align: center;">Notify Bowers & Associates</p> <p>Members must contact Bowers and Associates at 800-827-6730 for Pre-Certification, Case Management, or Health Advocacy.</p> <p>Members should contact UHC at 800-549-9226 for Medical, Mental Health, or Substance Use Disorder claims and benefit inquiries.</p>				
<p>9. Emergency Health Services</p> <p>Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.</p>	<u><i>Network</i></u> No	10%	Yes	Yes
<p>You will find more information about Benefits for Emergency Health Services in (Section 3: Description of Network and Non-Network Benefits).</p>	<u><i>Non-Network</i></u> No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Notify Bowers & Associates:				
Members must contact Bowers and Associates at 800-827-6730 for Pre-Certification, Case Management, or Health Advocacy.				
Members should contact UHC at 800-549-9226 for Medical, Mental Health, or Substance Use Disorder claims and benefit inquiries.				
If you don't notify Bowers & Associates, Benefits for the non-Network Hospital Inpatient Stay will be reduced by \$200.				
Benefits will not be reduced for the outpatient Emergency Health Services.				
10. Eye Examinations				
Eye examinations received from a health care provider in the provider's office.	<u>Network</u> No	No Copayment	No	No
Benefits include one routine vision exam, including refraction, to detect vision impairment by a Network Provider each calendar year.				
Benefits for lenses (Single, Bifocal, Trifocal or Lenticular) are limited to one pair per calendar year.	<u>Non-Network</u> No	No Copayment	No	No

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Benefits for progressive bifocals are also limited to one pair per calendar year. There is an additional limit of \$150 per calendar year that applies to progressive bifocals only.				
Benefits for contact lenses are limited to one set every 2 calendar years, to a maximum benefit of \$80.				
Benefits for frames are limited to one pair every 2 calendar years, to a maximum benefit of \$59.				
Benefits are available for glasses or contact lenses in any 2-calendar-year period – not both.				
The following services are covered:				
<ul style="list-style-type: none"> Protective lenses following a cataract operation or aphakia surgery. 				
Covered Health Services for the diagnosis and treatment of a Sickness or Injury received in a Physician's office.	<u>Network</u> No	10%	Yes	Yes
	<u>Non-Network</u> No	25%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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11. Hearing Aids for Children under the age of 18

Network
No

10%

Yes

Yes

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

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits under this section do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in the Certificate, only for Covered Persons who have either of the following:

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

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>Benefits under this section include hearing aids for Enrolled Dependent children under 18 years of age as required under Wisconsin insurance law.</p> <p>For Enrolled Dependent children under age 18, benefits are limited to one hearing aid per ear, every three years as required by Wisconsin insurance law. Hearing aids for Enrolled Dependent children are not subject to dollar maximums.</p>	<u>Non-Network</u> No	25%	Yes	Yes
<p>12. Home Health Care Services received from a Home Health Agency that are both of the following:</p> <ul style="list-style-type: none"> • Ordered by a Physician. • Provided by or supervised by a registered nurse in your home. 	<u>Network</u> No	10%	Yes	Yes
<p>Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required.</p> <p>Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:</p>	<u>Non-Network</u> Yes	25%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> • It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient. • It is ordered by a Physician. • It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair. • It requires clinical training in order to be delivered safely and effectively. • It is not Custodial Care. <p>We and the Claims Administrator will decide if skilled care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.</p> <p>Any combination of Network and Non-Network Benefits is limited to 100 visits per calendar year. One visit equals four hours of skilled care services.</p>				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Notify Bowers & Associates				
Please remember that for non-Network Benefits you should notify Bowers & Associates four business days before receiving services.				
If you don't notify Bowers & Associates, benefits will be reduced by \$200.				
Members must contact Bowers and Associates at 800-827-6730 for Pre-Certification, Case Management, or Health Advocacy.				
Members should contact UHC at 800-549-9226 for Medical, Mental Health, or Substance Use Disorder claims and benefit inquiries.				

13. Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact the Claims Administrator for more information regarding guidelines for hospice care. You can contact the Claims Administrator at the telephone number on your ID card.

Network

No

10%

Yes

Yes

Non-Network

Yes

25%

Yes

Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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Notify Bowers & Associates

Please remember that for non-Network Benefits you should notify Bowers & Associates five business days before receiving services.

If you don't notify Bowers & Associates, benefits will be reduced by \$200.

Members must contact Bowers and Associates at 800-827-6730 for Pre-Certification, Case Management, or Health Advocacy.

Members should contact UHC at 800-549-9226 for Medical, Mental Health, or Substance Use Disorder claims and benefit inquiries.

14. Hospital - Inpatient Stay

Inpatient Stay in a Hospital. Benefits are available for:

Network
No

10%

Yes

Yes

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

Benefits for Physician services are described under *Professional Fees for Surgical and Medical Services*.

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Notify Bowers & Associates:				
Please remember that you must notify Bowers & Associates as follows:	<u><i>Non-Network</i></u> Yes	25%	Yes	Yes
<ul style="list-style-type: none"> For elective admissions: four business days before admission. For non-elective admissions: within one business day or the same day of admission. For Emergency admissions: within 72 hours or the same day of admission, or as soon as is reasonably possible. 				
Members must contact Bowers and Associates at 800-827-6730 for Pre-Certification, Case Management, or Health Advocacy.				
Members should contact UHC at 800-549-9226 for Medical, Mental Health, or Substance Use Disorder claims and benefit inquiries.				
If you don't notify Bowers & Associates, Benefits will be reduced by \$200.				
15. Injections received in a Physician's Office	<u><i>Network</i></u> No	10% per injection	Yes	Yes
Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.				
	<u><i>Non-Network</i></u> No	25% per injection	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>16. Maternity Services</p> <p>Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.</p> <p>We will pay Benefits for an Inpatient Stay of at least:</p> <ul style="list-style-type: none"> • 48 hours for the mother and newborn child following a normal vaginal delivery. • 96 hours for the mother and newborn child following a cesarean section delivery. <p>If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.</p> <p style="text-align: center;">Notify Bowers & Associates</p> <p>Please remember that for Benefits you must notify Bowers & Associates as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described.</p> <p>Members must contact Bowers and Associates at 800-827-6730 for Pre-Certification, Case Management, or Health Advocacy.</p>	<p style="text-align: center;"><u>Network</u></p> <p style="text-align: center;">No</p>	<p style="text-align: center;">Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Surgery, Diagnostic and Therapeutic Services.</p>		
	<p style="text-align: center;"><u>Non-Network</u></p> <p style="text-align: center;">Yes, if Inpatient Stay exceeds time frames.</p>	<p style="text-align: center;">Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Surgery, Diagnostic and Therapeutic Services.</p>		

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Members should contact UHC at 800-549-9226 for Medical, Mental Health, or Substance Use Disorder claims and benefit inquiries.				
<p>17. Mental Health Services</p> <p>Mental Health Services include those received on an inpatient basis in a Hospital or Alternate Facility, and those received on an outpatient basis in a provider’s office or at an Alternate Facility.</p> <p>Benefits include the following services provided on either an outpatient or inpatient basis:</p> <ul style="list-style-type: none"> • Diagnostic evaluations and assessment. • Treatment planning. • Referral services. • Medication Management. • Individual, family, therapeutic group and provider-based case management services. • Crisis intervention. <p>Benefits include the following services provided on an inpatient basis:</p> <ul style="list-style-type: none"> • Partial hospitalization/day treatment. • Services at a Residential Treatment Facility. 	<p><u><i>Network</i></u></p> <p>You must call the Mental Health/ Substance Use Disorder Administrator to receive Inpatient Benefits.</p>	10%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Benefits include the following services on an outpatient basis:				
<ul style="list-style-type: none"> Intensive outpatient treatment. 				
The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.				
You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.				
Notification Required				
Please remember that you must notify the MH/SUD Administrator to receive inpatient Benefits. Please call the phone number that appears on your ID card.	<u>Non-Network</u> You must call the Mental Health/ Substance Use Disorder Administrator to receive Inpatient Benefits.	25%	Yes	Yes
Without authorization, Benefits will be reduced by \$200.				
18. Morbid Obesity Treatment				
Morbid Obesity Treatment includes the following treatments that are Medically Necessary and appropriate for an individual's Morbid Obesity condition.	<u>Network</u> No	10%	Yes	Yes
<ul style="list-style-type: none"> Charges for diagnostic services. 				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> Gastric or intestinal bypasses. Stomach stapling. <p>This Plan does not cover diet supplements, exercise equipment or any other items listed in the General Exclusions.</p> <p>Morbid Obesity means a Covered Person who weighs more than 100 pounds over standard weight for height, sex and age; or a Covered Person who weighs more than two times the standard weight for height, sex and age; or for a Covered Person who is less than 19 years of age, Morbid Obesity means that the Covered Person's weight is 50% greater than ideal body weight.</p>	<u>Non-Network</u> No	25%	Yes	Yes
<p>19. Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders</p> <p>The Plan pays Benefits for psychiatric services for Autism Spectrum Disorders that are both of the following:</p> <ul style="list-style-type: none"> Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider. Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning. 	<u>Network</u> You must call the Mental Health/ Substance Use Disorder Administrator to receive Inpatient Benefits.	10%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following services provided on either an outpatient or inpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis.

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> Intensive Outpatient Treatment. <p>The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.</p> <p>You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.</p> <p style="text-align: center;">Notification Required</p> <p>Please remember that you must notify the MH/SUD Administrator to receive inpatient Benefits. Please call the phone number that appears on your ID card.</p> <p>Without authorization, Benefits will be reduced by \$200.</p>	<p><u>Non-Network</u></p> <p><u>You must call the Mental Health/ Substance Use Disorder Administrator to receive Inpatient Benefits.</u></p>	25%	Yes	Yes
<p>20. Ostomy Supplies</p> <p>Benefits for ostomy supplies include only the following:</p> <ul style="list-style-type: none"> Pouches, face plates and belts. Irrigation sleeves, bags and catheters. 	<p><u>Network</u></p> <p>No</p>	10%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> • Skin barriers. <p>Benefits are not available for gauze, adhesive, adhesive remover, deodorant, pouch covers, or other items not listed above.</p>	<p><u>Non-Network</u> No</p>	25%	Yes	Yes
<h2>21. Outpatient Surgery, Diagnostic and Therapeutic Services</h2>				
<p><i>Outpatient Surgery</i></p>	<p><u>Network</u> No</p>	10%	Yes	Yes
<p>Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:</p>				
<ul style="list-style-type: none"> • Benefits under this section include only the facility charge and the charge for required Hospital-based professional services, supplies and equipment. Benefits for the surgeon fees related to outpatient surgery are described under <i>Professional Fees for Surgical and Medical Services</i>. 				
<p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> below.</p>	<p><u>Non-Network</u> No</p>	25%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p><i>Outpatient Diagnostic Services</i> Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:</p> <ul style="list-style-type: none"> • Lab and radiology/X-ray. • Mammography testing. <p>Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> below.</p>	<p><u>Network</u> No No</p>	<p><i>For Preventive lab and radiology/X-ray:</i> No Copayment <i>For Preventive mammography testing:</i> No Copayment</p>	<p>No No</p>	<p>No No</p>
<p><u>Routine Physical Exams:</u></p> <p>With respect to services rendered by a Network Provider, routine physical exam for You and Your spouse 20-40 years of age, one exam every 5 calendar years. Thereafter, one exam every 2 calendar years until You retire. Eligible dependents 36 months to 19 years of age, one exam every 2 calendar years, and eligible dependents age 20-27, one exam every 5 calendar years. Deductible and Coinsurance shall not apply.</p>		<p><i>For sickness and injury-related diagnostic services:</i> 10%</p>	<p>Yes</p>	<p>Yes</p>
<p>With respect to services rendered by a Non-Network Provider, routine physical exams shall be payable to the above frequency schedule. The maximum amount payable is \$125 per exam per calendar year. Deductible and Coinsurance apply.</p>				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>With respect to services rendered by a Network Provider, 6 Well-Baby Care exams from age 0 to 12 months; 3 exams from age 13 to 35 months. The Deductible shall not apply.</p>				
<p>With respect to services rendered by a Non-Network Provider, benefits shall be payable according to the above frequency schedule. The maximum amount payable is \$25 per exam per calendar year. The Deductible and Coinsurance do apply.</p>				
<p><u>Immunizations:</u></p>				
<p>Immunizations for Dependent children and adults according to medically recognized guidelines.</p>				
<p><u>Pap Tests:</u></p>	<u>Non-Network</u>			
<p>Pap tests and pelvic or gynecological exams according to the following schedule:</p>	No	25%	Yes	Yes
<ul style="list-style-type: none"> • For women ages 18-39, once every calendar year. • For women age 40 and over, once every 2 calendar years. 				
<p><u>Mammograms:</u></p>				
<p>Mammograms according to the following schedule:</p>				
<ul style="list-style-type: none"> • For women ages 40-49, once every 2 calendar years. • For women age 50 and over, one every calendar year. 				
<p>Mammograms for the diagnosis of Illness shall be payable the same as any other Illness.</p>				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<u>Colon Cancer Screening:</u>				
Fecal occult blood test, every calendar year beginning at age 50.				
<u>Prostate Cancer Screening:</u>				
Prostate Specific Antigen (PSA), every 2 calendar years beginning at age 50.				
<u>Skin Cancer Screening:</u>				
With respect to services rendered by a Network Provider, the Deductible and Coinsurance shall not apply.				
With respect to services rendered by a Non-Network Provider, the Deductible and Coinsurance shall apply.				
<i>Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine</i>	<u>Network</u> No	10%	Yes	Yes
Covered Health Services for CT scans, PET scans, MRI, and nuclear medicine received on an outpatient basis at a Hospital or Alternate Facility.				
Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.	<u>Non-Network</u> No	25%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p><i>Outpatient Therapeutic Treatments</i></p> <p>Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.</p>	<u>Network</u> No	10%	Yes	Yes
<p>Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.</p> <p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> below.</p>	<u>Non-Network</u> No	25%	Yes	Yes
<p>22. Physician's Office Services</p> <p>Covered Health Services for preventive medical care.</p> <p>Preventive medical care includes:</p>	<u>Network</u> No	No Copayment	No	No
<ul style="list-style-type: none"> • Voluntary family planning. • Well-baby and well-child care. • Routine physical examinations. • Immunizations. 				
<p><u>Routine Physical Exams:</u></p>				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>With respect to services rendered by a Network Provider, routine physical exam for You and Your spouse 20-40 years of age, one exam every 5 calendar years. Thereafter, one exam every 2 calendar years until You retire. Eligible dependents 36 months to 19 years of age, one exam every 2 calendar years, and eligible dependents age 20-27, one exam every 5 calendar years. Deductible and Coinsurance shall not apply.</p>				
<p>With respect to services rendered by a Non-Network Provider, routine physical exams shall be payable to the above frequency schedule. The maximum amount payable is \$125 per exam per calendar year. Deductible and Coinsurance apply.</p>				
<p>With respect to services rendered by a Network Provider, 6 Well-Baby Care exams from age 0 to 12 months; 3 exams from age 13 to 35 months. The Deductible shall not apply.</p>				
<p>With respect to services rendered by a Non-Network Provider, benefits shall be payable according to the above frequency schedule. The maximum amount payable is \$25 per exam per calendar year. The Deductible and Coinsurance do apply.</p>				
<p><u>Immunizations:</u></p>				
<p>Immunizations for Dependent children and adults according to medically recognized guidelines.</p>				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<u>Pap Tests:</u>	<u>Non-Network</u> No	<i>Routine Physical Exams:</i> 25% of eligible expenses after deductible, to a maximum benefit of \$125.	Yes	Yes
Pap tests and pelvic or gynecological exams according to the following schedule: <ul style="list-style-type: none">For women ages 18-39, once every calendar year.For women age 40 and over, once every 2 calendar years.				
<u>Contraceptives:</u>		<i>Well-Baby Care Exams:</i>		
Prescription contraceptives that require a Physician to administer a hormone shot or insert a device		25% of eligible expenses after deductible, to a maximum benefit of \$25,	Yes	Yes
<u>Mammograms:</u>		<i>All Other Preventive Services:</i>		
Mammograms according to the following schedule: <ul style="list-style-type: none">For women ages 40-49, once every 2 calendar years.For women age 50 and over, one every calendar year.		25% of eligible expenses after deductible.	Yes	Yes
Mammograms for the diagnosis of Illness shall be payable the same as any other Illness.				
<u>Colon Cancer Screening:</u>				
Fecal occult blood test, every calendar year beginning at age 50.				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<u>Prostate Cancer Screening:</u>				
Prostate Specific Antigen (PSA), every 2 calendar years beginning at age 50.				
<u>Skin Cancer Screening:</u>				
With respect to services rendered by a Network Provider, the Deductible and Coinsurance shall not apply.				
With respect to services rendered by a Non-Network Provider, the Deductible and Coinsurance shall apply.				
Covered Health Services for the diagnosis and treatment of a Sickness or Injury received in a Physician's office.	<u>Network</u> No	10%	Yes	Yes
	<u>Non-Network</u> No	25%	Yes	Yes
23. Podiatry Services	<u>Network</u> No	20%	Yes	Yes
	<u>Non-Network</u> No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<h3>24. Professional Fees for Surgical and Medical Services</h3> <p>Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.</p> <p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> above.</p>	<u>Network</u> No	10%	Yes	Yes
	<u>Non-Network</u> No	25%	Yes	Yes
<h3>25. Prosthetic Devices</h3> <p>External prosthetic devices that replace a limb or an external body part, limited to:</p> <ul style="list-style-type: none"> • Artificial arms, legs, feet and hands. • Artificial eyes, ears and noses. • Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm. <p>If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.</p>	<u>Network</u> No	10%	Yes	Yes
	<u>Non-Network</u> No	25%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>26. Reconstructive Procedures</p> <p>Services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function.</p>	<p><u>Network</u> No</p>	<p>Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.</p>		
<p>Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.</p>	<p><u>Non-Network</u> Yes</p>	<p>Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.</p>		
<p>Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact the Claims Administrator</p>				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

Notify Bowers & Associates

Non-Network Services: Please remember that you must notify Bowers & Associates five business days before receiving services. When you provide notification, Bowers & Associates can verify that the service is a reconstructive rather than a Cosmetic Procedure. Cosmetic procedures are always excluded from coverage.

Members must contact Bowers and Associates at 800-827-6730 for Pre-Certification, Case Management, or Health Advocacy.

Members should contact UHC at 800-549-9226 for Medical, Mental Health, or Substance Use Disorder claims and benefit inquiries.

If you don't notify Bowers & Associates, benefits will be reduced by \$200.

27. Rehabilitation Services - Outpatient Therapy

Network
No

10%

Yes

Yes

Short-term outpatient rehabilitation services for:

- Physical therapy.
- Occupational therapy.
- Massage therapy (covered if services rendered by a Physical Therapist or Chiropractor).

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> • Speech therapy. • Respiratory therapy. • Pulmonary rehabilitation therapy. • Cardiac rehabilitation therapy. <p>Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician.</p> <p>The Plan allows coverage for occupational, physical, or speech therapy for Developmental Disorders such as Autism, Downs Syndrome, Cerebral Palsy and other Developmental Disorders.</p> <p>Speech therapy by a Qualified speech therapist is covered only for habilitative and rehabilitative services required due to an Illness, Injury, surgical procedure, mental retardation, or Developmental Disorder. This includes therapy for a stuttering disorder.</p> <p>This Plan does not cover services that should legally be provided by a school.</p> <p>Therapy services are excluded if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve the condition, or that clinical evidence indicates that a plateau has been reached in terms of improvement from such services.</p>	<u>Non-Network</u>	25%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>28. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</p> <p>Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:</p> <ul style="list-style-type: none"> • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). <p>Any combination of Network and Non-Network Benefits is limited to 30 days per calendar year.</p> <p>Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital.</p>	<u>Network</u> No	10%	Yes	Yes
<p style="text-align: center;">Notify Bowers & Associates</p> <p>Non-Network Services: Please remember that you must notify Bowers & Associates as follows:</p>	<u>Non-Network</u> Yes	20%	Yes	Yes
<ul style="list-style-type: none"> • For elective admissions: five business days before admission. • For non-elective admission: within one business day or the same day of admission. • For Emergency admission: within one business day or the same day of admission or as soon it is reasonably possible. 				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Members must contact Bowers and Associates at 800-827-6730 for Pre-Certification, Case Management, or Health Advocacy.				
Members should contact UHC at 800-549-9226 for Medical, Mental Health, or Substance Use Disorder claims and benefit inquiries.				
If you don't notify Bowers & Associates, benefits will be reduced by \$200.				
29. Spinal Treatment				
Chiropractic services are excluded if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve the condition, or that clinical evidence indicates that a plateau has been reached in terms of improvement from such services.	<u>Network</u> No	20%	Yes	Yes
	<u>Non-Network</u> No	20%	Yes	Yes
30. Substance Use Disorder Services				
Substance Use Disorder Services include those received on an inpatient basis in a Hospital or an Alternate Facility and those received on an outpatient basis in a provider's office or at an Alternate Facility.	<u>Network</u> You must call the Mental Health/ Substance Use Disorder	10%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Benefits include the following services provided on either an inpatient or outpatient basis:	Administrator to receive Inpatient Benefits.			
<ul style="list-style-type: none"> • Diagnostic evaluations and assessment. • Treatment planning. • Referral services. • Medication management. • Individual, family, therapeutic group and provider-based case management. • Crisis intervention. • Detoxification (sub-acute/non-medical). 				
Benefits include the following services provided on an inpatient basis:				
<ul style="list-style-type: none"> • Partial Hospitalization/Day Treatment. • Services at a Residential Treatment Facility. 	Administrator to receive Inpatient Benefits.			
Benefits include the following services provided on an outpatient basis:				
<ul style="list-style-type: none"> • Intensive Outpatient Treatment. 				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.</p> <ul style="list-style-type: none"> You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care. 				
<p>Notification Required</p> <p>Please remember that you must notify the MH/SUD Administrator to receive inpatient Benefits. Please call the phone number that appears on your ID card.</p> <p>Without authorization, Benefits will be reduced by \$200.</p>	<p><u>Non-Network</u></p> <p>You must call the Mental Health/ Substance Use Disorder Administrator to receive Inpatient Benefits.</p>	<p>25%</p>	<p>Yes</p>	<p>Yes</p>
<p>31. Temporomandibular Joint Dysfunction (TMJ)</p> <p>Benefits for diagnostic procedures and non-surgical treatment are limited to \$1,250 per calendar year.</p>	<p><u>Network</u></p> <p>No</p>	<p>Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Diagnostic and Therapeutic Services.</p>		

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>Covered services include intraoral devices or any other non-surgical method to alter the occlusion and/or vertical dimension. TMJ shall mean a disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly. This does not cover orthodontic services.</p> <p>Orthognathic, Prognathic, and Maxillofacial Surgery are covered when Medically Necessary, except LeForte I, II, and III osteotomies.</p>	<p><u>Non-Network</u> No</p>	<p>Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Diagnostic and Therapeutic Services.</p>		
<p>32. Transplantation Services</p> <p>This coverage provides a choice for transplant care. Use of a Designated Transplant Facility provides incentives to You and Your covered Dependents. This coverage doesn't require that a Designated Transplant Facility be used in order to receive benefits, but it is preferred. Designated Transplant Facilities are facilities that must meet extensive criteria in the areas of patient outcomes to include patient and graft survival, patient satisfaction, Physician and program experience, program accreditations, and patient and caregiver education.</p> <p>The Plan will pay for Covered Expenses incurred by a Covered Person at a Designated or Non-designated Transplant Facility for an Illness or Injury, subject to any Deductibles, Coinsurance amounts, maximums or limits shown in the Summary Plan Description (SPD).</p>	<p><u>Network</u> Yes</p>	<p>10%</p>	<p>Yes</p>	<p>Yes</p>

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>The Plan will pay for Approved Transplant Services at a Designated or Non-Designated Transplant Facility for Organ and Tissues Acquisition/Procurement and transplantation, if a Covered Person is the recipient.</p>				
<p>If a Covered Person requires a transplant, including bone marrow or stem cell transplant, the cost of Organ and Tissue Acquisition/Procurement from a living human or cadaver will be included as part of the Covered Person's Covered expenses when the donor's own plan does not provide coverage for Organ and Tissue Acquisition/Procurement. This includes the cost of donor testing, blood typing and evaluation to determine if the donor is a suitable match.</p>				
<p>The Plan will provide donor services at a non-designated facility for initial acquisition/procurement only, up to the maximum listed in the Summary Plan Description, if any. Complications, side effects or injuries are not covered unless the donor is a Covered Person on the plan.</p>				
<p>Examples of transplants for which Benefits are available include but are not limited to:</p>				
<ul style="list-style-type: none"> • Kidney. • Kidney/Pancreas. 				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> Expenses for Organ and Tissue Acquisition/Procurement and storage of cord blood, stem cells or bone marrow, unless the Covered Person has been diagnosed with a condition for which there would be a transplant benefit approved by the Plan. Expenses for any post-transplant complications of the donor, if the donor is not a Covered Person under this Plan. Transplants considered Experimental, Investigational or unproven. Solid organ transplant in patients with carcinoma unless the carcinoma is in complete remission for five (5) years or considered cured. Solid organ transplantation for conditions that are not considered Medically Necessary and/or appropriate, as determined by the Plan. Expenses related to the purchase of any organ. 				

Notify Bowers & Associates

For Network or Non-Network Benefits, you or your Physician must notify Bowers & Associates as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
33. Urgent Care Center Services Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under <i>Physician's Office Services</i> earlier in this section.	<u>Network</u> No	10%	Yes	Yes
	<u>Non-Network</u> No	25%	Yes	Yes

Section 2: What's Not Covered-- Exclusions

This section contains information about:

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

How We Use Headings in this Section

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

We Do not Pay Benefits for Exclusions

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

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

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

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

A. Alternative Treatments

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

B. Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/Barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
 - Air conditioners.
 - Air purifiers and filters.
 - Batteries and battery chargers.
 - Dehumidifiers.
 - Humidifiers.
6. Devices and computers to assist in communication and speech.

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

C. Dental

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

D. Drugs

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

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

E. Experimental, Investigational or Unproven Services

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

F. Foot Care

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

G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
 - Ace bandages.

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

- Gauze and dressings.
 - Syringes.
 - Diabetic test strips.
3. Tubings and masks are not covered except when used with Durable Medical Equipment as described in (Section 1: What's Covered--Benefits).

H. Mental Health/Substance Use Disorder

Exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders* and/or *Substance Use Disorder Services* as described in (Section 1: What's Covered--Benefits).

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that , in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:
 - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
 - Not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time.

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

- Not clinically appropriate for the patient's Mental Illness, Substance Use Disorder or condition based on generally accepted standards of medical practice and benchmarks.
3. Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
 4. Mental Health Services as treatment for a primary diagnosis of insomnia other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.
 5. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias (sexual behavior that is considered deviant or abnormal).
 6. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
 7. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.
 8. Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
 9. Mental retardation as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
 10. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction.
 11. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders.

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

12. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

I. Nutrition

1. Megavitamin and nutrition based therapy.
2. Nutritional counseling for either individuals or groups.
3. All enteral feedings, supplemental feedings, over-the-counter nutritional and electrolyte supplements and for related supplies including feeding tubes, pumps, bags and products, unless documented as the sole source of nutrition.

J. Physical Appearance

1. Cosmetic Procedures. See the definition in (Section 10: Glossary of Defined Terms). Examples include:
 - Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
 - Skin abrasion procedures performed as a treatment for acne.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.
Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in (Section 1: What's Covered--Benefits).

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

3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
4. Except as specifically described elsewhere in this document, weight loss programs whether or not they are under medical supervision.
5. Wigs regardless of the reason for the hair loss.
6. Breast reduction surgery is covered only when deemed Medically Necessary.

K. Providers

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

L. Reproduction

1. Health services and associated expenses for infertility treatments.

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

2. Surrogate parenting.
3. The reversal of voluntary sterilization.
4. Contraceptive medications or devices that You self administer (oral tables, patches, self-injectable vaginal devices, etc).

M. Services Provided under Another Plan

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

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

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

N. Transplants

1. Health services for organ and tissue transplants, except those described in (Section 1: What's Covered--Benefits), unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan).

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

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

O. Travel

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

P. Vision and Hearing

1. Any services or materials in connection with:
 - Orthoptics or vision therapy procedures;
 - Subnormal vision aids;
 - Aniseikonia lenses;
 - Tinted lenses;
 - Plano (non-prescription) lenses;
 - Plano sunglasses;
 - Anti-reflective coating or any coated or laminated lenses;
 - Oversized lenses;
 - Photochromatic lenses; or
 - Two pair of glasses in lieu of bifocals.
2. Replacement of any lost or broken lens or frames.
3. Any services or materials required as a condition of employment, including but not limited to industrial safety glasses.

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

4. Specialized diagnostic services or other procedures required for contact lenses not included in the basic vision examination.
5. Any vision care services for which the Covered Person is reimbursed, entitled to reimbursement or is in any way indemnified for such expenses by or through any public programs, state, federal or local.
6. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.
7. The purchase or fitting of hearing aids except as described in (Section 1: What's Covered--Benefits) under the heading *Hearing Aids for Children under the age of 18*, Soundtec implants or cochlear implants.
8. Purchase cost and associated fitting and testing charges for hearing aids, bone anchored hearing aids and all other hearing assistive devices, except as described in (Section 1: What's Covered--Benefits) under the heading *Hearing Aids for Children under the age of 18*.

Q. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in (Section 10: Glossary of Defined Terms).
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
 - Required solely for purposes of career, education (physicals for education are covered if done at an on-site clinic), sports (physicals for sports are covered if done at an on-site clinic)

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or camp, travel, employment, insurance, marriage or adoption.

- Related to judicial or administrative proceedings or orders.
 - Conducted for purposes of medical research.
 - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
 4. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
 5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
 6. In the event that a non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments and/or Annual Deductible are waived.
 7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
 8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are dental in nature.
 9. Growth hormone therapy.
 10. Sex transformation operations.
 11. Custodial Care.
 12. Domiciliary care.
 13. Private duty nursing.
 14. Respite care.
 15. Rest cures.
 16. Psychosurgery.

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17. Treatment of benign gynecomastia (abnormal breast enlargement in males), unless deemed Medically Necessary.
18. Medical and surgical treatment of excessive sweating (hyperhidrosis).
19. Panniculectomy, abdominoplasty, thighplasty, brachioplasty, mastopexy, and breast reduction. This exclusion does not apply to breast reconstruction following a mastectomy as described under *Reconstructive Procedures* in (Section 1: What's Covered--Benefits).
20. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
21. Oral appliances for snoring.
22. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly.
23. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
24. Any charge for services, supplies or equipment advertised by the provider as free.
25. Any charges prohibited by federal anti-kickback or self-referral statutes.
26. Appointments Missed: An appointment the Covered Person did not attend.
27. Aquatic Therapy.
28. Assistant Surgeon Services, unless determined Medically Necessary by the Plan.
29. Bereavement Counseling.
30. Blood: Blood donor expenses.
31. Cardiac Rehabilitation beyond Phase II.
32. Chelation Therapy, except in the treatment of conditions considered Medically Necessary, medically appropriate and not Experimental or Investigational for the medical condition for which the treatment is recognized.
33. Counseling Services in connection with marriage, pastoral or financial counseling, unless covered elsewhere in this Plan.
34. Criminal Activity: Illness or Injury resulting from taking part in the commission of an assault or battery (or a similar crime against a person) or a felony. The Plan shall enforce this exclusion based upon reasonable information showing that this Criminal Activity took place.
35. Education: Charges for education, special education, job training, music therapy and recreational therapy, whether or not given in a facility providing medical or psychiatric care.
36. Employment or Worker's Compensation: An illness or injury arising out of or in the course of any employment for wage or profit, including self-employment, for which the Covered Person was or could have been entitled to benefits under any Worker's Compensation, U.S. Longshoremen and Harbor Worker's or other occupational disease legislation, policy or contract, whether or not such policy or contract is actually in force. This exclusion applies whether or not the Covered Person claims the benefits or compensation and whether or not the Covered Person recovers losses from a third party.
37. Extended Care: Any Extended Care Facility Services which exceed the appropriate level of skill required for treatment as determined by the Plan.
38. Family Planning: Consultation for family planning.
39. Genetic counseling, studies, testing or surgery based only on a family history of having a disease, rather than on medical necessity for an existing problem.

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40. Home Modifications: Modifications to Your home or property such as but not limited to, escalator(s), elevators, saunas, steam-baths, pools, hot tubs, whirlpools, or tanning equipment, wheelchair lifts, stair lifts or ramps.
41. Infertility Treatment and direct attempts to achieve pregnancy by any means. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.
42. Inpatient Hospital Admissions which are primarily for physical, speech, occupational or radiation therapy unless the Inpatient confinement is determined to be Medically Necessary by the Plan.
43. Interest and Legal Fees.
44. Lamaze Classes or other child birth classes.
45. Learning Disability: Special education, remedial reading, school system testing and other rehabilitation treatment for a Learning Disability. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.
46. LeForte I, II and III Osteotomies.
47. Maintenance Therapy: Such services are excluded if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve the condition, or that clinical evidence indicates that a plateau has been reached in terms of improvement from such services.
48. Maternity Costs for Covered Person other than the employee or spouse.
49. Non-Professional Care: Medical or surgical care that is not performed according to generally accepted professional standards.
50. Not Medically Necessary: Services, supplies, treatment, facilities or equipment which the Plan determines are not Medically Necessary.
51. Nursery and Newborn Expenses for grandchildren of covered Employee or spouse.
52. Penalties.
53. Repairs: Maintenance or repair of Durable Medical Equipment due to abuse or misuse of equipment.
54. Return to Work/School: Telephone consultations or completion of claim forms or forms necessary for the return to work or school.
55. Room and Board Fees when surgery is performed other than at a Hospital or Surgical Center.
56. Services At No Cost: Services which the Covered Person would not be obligated to pay in the absence of this Plan or which are available to the Covered Person at no cost, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense code, or as required by law.
57. Sex Therapy.
58. Sexual Function: Any medications, oral or other, used to increase sexual function or satisfaction or penile pumps and erect aid devices.
59. Taxes: Sales taxes, shipping and handling.
60. Telemedicine or Telephone Consultations.
61. Vocational Testing, Evaluation and Counseling: Vocational and educational services rendered primarily for training or education purposes.
62. Warning Devices: Warning devices, stethoscope, blood pressure cuffs or other types of apparatus used for diagnosis or monitoring, unless covered elsewhere in this Plan.

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Section 3: Description of Network and Non-Network Benefits

This section includes information about:

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

Network Benefits

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

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

Comparison of Network and Non-Network Benefits

	Network	Non-Network
Benefits	A higher level of Benefits means less cost to you. See	A lower level of Benefits means more cost to you. See

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	Network	Non-Network
	(Section 1: What's Covered--Benefits).	(Section 1: What's Covered--Benefits).
Who Should Notify the Claims Administrator for Care Coordination	Members must contact Bowers and Associates at 800-827-6730 for Pre-Certification, Case Management, or Health Advocacy.	Members must contact Bowers and Associates at 800-827-6730 for Pre-Certification, Case Management, or Health Advocacy.
	Members should contact UHC at 800-549-9226 for Medical, Mental Health, or Substance Use Disorder claims and benefit inquiries.	Members should contact UHC at 800-549-9226 for Medical, Mental Health, or Substance Use Disorder claims and benefit inquiries.
Who Should File Claims	Not required. We pay Network providers directly.	You must file claims. See (Section 5: How to File a Claim).
Outpatient Emergency Health Services	Emergency Health Services are always paid as a Network Benefit (paid the same whether you are in or out of the Network). That means that if you seek Emergency care at a non-Network facility, you are not required to meet the Annual Deductible or to pay any difference between Eligible Expenses and the amount the provider bills.	

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Provider Network

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

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

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

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

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

Care Coordination

Members must contact Bowers and Associates at 800-827-6730 for Pre-Certification, Case Management, or Health Advocacy.

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Members should contact UHC at 800-549-9226 for Medical, Mental Health, or Substance Use Disorder claims and benefit inquiries.

Designated Facilities and Other Providers

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

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

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

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify the Claims

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Administrator, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

Limitations on Selection of Providers

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

If you don't make a selection within 31 days of the date we notify you, the Claims Administrator will select a single Network Physician for you.

If you fail to use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

Non-Network Benefits

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

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

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Program providers than from other non-Network providers, because the Eligible Expense may be a lesser amount.

Notification Requirement

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

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

Care Coordination

Members must contact Bowers and Associates at 800-827-6730 for Pre-Certification, Case Management, or Health Advocacy.

Members should contact UHC at 800-549-9226 for Medical, Mental Health, or Substance Use Disorder claims and benefit inquiries.

Emergency Health Services

We provide Benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

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

If you are confined in a non-Network Hospital after you receive Emergency Health Services, the Claims Administrator must be notified within one business day or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to

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do so. If you choose to stay in the non-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

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Section 4: When Coverage Begins

This section includes information about:

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

How to Enroll

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

If You Are Hospitalized When Your Coverage Begins

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

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Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

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

If You Are Eligible for Medicare

Your Benefits under the Plan may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under both Medicare Part A and Part B.

Your Benefits under the Plan may also be reduced if you are enrolled in a Medicare Advantage (Medicare Part C) plan but fail to follow the rules of that plan. Please see *Medicare Eligibility* in (Section 9: General Legal Provisions) for more information about how Medicare may affect your Benefits.

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Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Eligible Person	<p>Eligible Person usually refers to an employee of ours who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Participant. For a complete definition of Eligible Person and Participant, see (Section 10: Glossary of Defined Terms).</p> <p>If both spouses are Eligible Persons under the Plan, each may enroll as a Participant or be covered as an Enrolled Dependent of the other, but not both.</p> <p>Except as we have described in (Section 4: When Coverage Begins), Eligible Persons may not enroll.</p>	<p>We determine who is eligible to enroll under the Plan.</p>
Dependent	<p>Dependent generally refers to the Participant's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see (Section 10: Glossary of Defined Terms).</p> <p>Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan.</p> <p>If both parents of a Dependent child are enrolled as a Participant, only one parent may enroll the child as a Dependent.</p> <p>Except as we have described in (Section 4: When Coverage Begins), Dependents may not enroll.</p>	<p>We determine who qualifies as a Dependent.</p>

When to Enroll and When Coverage Begins

When to Enroll	Who Can Enroll	Begin Date
<p>Initial Enrollment Period</p> <p>The Initial Enrollment Period is the first period of time when Eligible Persons can enroll.</p>	<p>Eligible Persons may enroll themselves and their Dependents.</p>	<p>Coverage begins on the date identified by the Plan Administrator, if the Plan Administrator receives the completed enrollment form and any required contribution for coverage within 31 days of the date the Eligible Person becomes eligible to enroll.</p>
<p>Open Enrollment Period</p>	<p>Eligible Persons may enroll themselves and their Dependents.</p>	<p>The Plan Administrator determines the Open Enrollment Period. Coverage begins on the date identified by the Plan Administrator if the Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the date the Eligible Person becomes eligible to enroll.</p>
<p>New Eligible Persons</p>	<p>New Eligible Persons may enroll themselves and their Dependents.</p>	<p>Coverage begins on the first day of the month following the completion of a 30 day waiting period if the Plan Administrator receives the properly completed enrollment form and any required contribution for coverage within 31 days of the date the new Eligible Person becomes eligible to enroll and if the Participant pays any required contribution to the Plan Administrator for Coverage.</p>
<p>Adding New Dependents</p>	<p>Participants may enroll Dependents who join their family because of any of the following events:</p>	<p>Coverage begins on the date of the event if the Plan Administrator received the completed enrollment form and any required contribution</p>

When to Enroll	Who Can Enroll	Begin Date
	<ul style="list-style-type: none"> • Birth. • Legal adoption. • Placement for adoption. • Marriage. • Legal guardianship. • Court or administrative order. 	<p>for coverage within 31 days of the event that makes the new Dependent eligible.</p>

Special Enrollment Period

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

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is elected.

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

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

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

- The Eligible Person previously declined coverage under the Plan, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP (you must notify the Plan Administrator within 60 days of determination of subsidy eligibility);
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and
- Coverage under the prior plan ended because of any of the following:
 - Loss of eligibility (including, without limitation, legal separation, divorce or death).

Event Takes Place (for example, a birth, marriage or determination of eligibility for state subsidy). Unless otherwise noted under the “Who Can Enroll” column, coverage begins on the date of the event if the Plan Administrator receives the completed enrollment information and any required contribution within 31 days of the event.

Missed Initial Enrollment Period or Open Enrollment Period. Unless otherwise noted under the “Who Can Enroll” column, coverage begins on the day immediately following the day coverage under the prior plan ends if the Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the date coverage under the prior plan ended.

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

- The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
- In the case of COBRA continuation coverage, the coverage ended.
- The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.
- The Plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
- Termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must notify the Plan Administrator within 60 days of termination).

Dependent Child Special Open Enrollment Period

On or before the first day of the plan year beginning on or after September 23, 2010, the Plan will provide a 30 day dependent child special open enrollment period for Dependent children who have not yet reached the limiting age. During this dependent child special open enrollment period, Eligible Persons who are adding a Dependent child and who have a choice of coverage options will be allowed to change options.

Coverage begins on the first day of the plan year beginning on or after September 23, 2010, if the Plan Administrator receives your properly completed enrollment form and any required contribution for coverage within 31 days of the date the Dependent becomes eligible to enroll under this dependent child special open enrollment period.

Section 5: How to File a Claim

This section provides you with information about:

- How and when to file a claim.
- If you receive Covered Health Services from a Network provider, you do not have to file a claim. We pay these providers directly.
- If you receive Covered Health Services from a non-Network provider, you are responsible for filing a claim.

If You Receive Covered Health Services from a Network Provider

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

Filing a Claim for Benefits

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us through the Claims Administrator. You must file the claim in a

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

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

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

Required Information

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

- A. Participant's name and address.
- B. The patient's name, age and relationship to the Participant.
- C. The member number stated on your ID card.
- D. An itemized bill from your provider that includes the following:
 - Patient diagnosis
 - Date of service
 - Procedure code(s) and description of service(s) rendered
 - Provider of service (Name, Address and Tax Identification Number)
- E. The date the Injury or Sickness began.
- F. A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

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Payment of Benefits

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

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

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

Benefit Determinations

Post-Service Claims

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

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is

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received. If you don't provide the needed information within the 45-day period, your claim will be denied.

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

Pre-Service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, you will receive written notice of the decision from the Claims Administrator within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, the Claims Administrator will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the appeal procedures.

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Urgent Requests for Benefits that Require Immediate Action

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

- You will receive notice of the benefit determination in writing or electronically within 24 hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

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

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

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

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

Concurrent Care Claims

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

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

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Section 6: Questions, Complaints and Appeals

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

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

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

What to Do First

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

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

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

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

How to Appeal a Claim Decision

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

Your request should include:

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

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

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Appeal Process

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

Appeals Determinations

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

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

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

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

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

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

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

For pre-service requests for Benefits and post-service claim appeals, we have delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Plan. The Claims Administrator's decisions are conclusive and binding.

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

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

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

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

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

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Section 7: Coordination of Benefits

This section provides you with information about:

- What you need to know when you have coverage under more than one plan.
- Definitions specific to Coordination of Benefit rules.
- Order of payment rules.

Benefits When You Have Coverage under More than One Plan

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

When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one benefit plan.

The order of benefit determination rules described in this section determine which Coverage Plan will pay as the Primary Coverage Plan. The Primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some

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expenses. A Secondary Coverage Plan pays after the Primary Coverage Plan and may reduce the benefits it pays. This is to prevent payments from all group Coverage Plans from exceeding 100 percent of the total Allowable Expense.

Definitions

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

1. "Coverage Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.
 - a. "Coverage Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; medical, no-fault, or personal injury protection (PIP) benefits under group or individual automobile contracts; medical benefits coverage under homeowner's insurance; and Medicare or other governmental benefits, as permitted by law.
 - b. "Coverage Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

Each contract for coverage under a. or b. above is a separate Coverage Plan. If a Coverage Plan has two parts and COB rules apply

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only to one of the two, each of the parts is treated as a separate Coverage Plan.

2. The order of benefit determination rules determine whether this Coverage Plan is a "Primary Coverage Plan" or "Secondary Coverage Plan" when compared to another Coverage Plan covering the person.

When this Coverage Plan is primary, its benefits are determined before those of any other Coverage Plan and without considering any other Coverage Plan's benefits. When this Coverage Plan is secondary, its benefits are determined after those of another Coverage Plan and may be reduced because of the Primary Coverage Plan's benefits.

3. "Allowable Expense" means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Coverage Plans is not an Allowable Expense. Dental care, and hearing aids except as described in (Section 1: What's Covered--Benefits) under the heading *Hearing Aids for Children under the age of 18* are examples of expenses or services that are not Allowable Expenses under the Plan. The following are additional examples of expenses or services that are not Allowable Expenses:
 - a. If a Covered Person is confined in a private Hospital room, the difference between the cost of a Semi-private Room in the Hospital and the private room, (unless the patient's stay in a private Hospital room is medically necessary in terms of generally accepted medical practice, or one of the Coverage Plans routinely provides coverage for Hospital private rooms) is not an Allowable Expense.

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- b. If a person is covered by two or more Coverage Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.
 - c. If a person is covered by two or more Coverage Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
 - d. If a person is covered by one Coverage Plan that calculates its benefits or services on the basis of usual and customary fees and another Coverage Plan that provides its benefits or services on the basis of negotiated fees, the Primary Coverage Plan's payment arrangements shall be the Allowable Expense for all Coverage Plans.
 - e. The amount a benefit is reduced by the Primary Coverage Plan because a Covered Person does not comply with the Coverage Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.
4. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.
 5. "Closed Panel Plan" is a Coverage Plan that provides health benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
 6. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with

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whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules

When two or more Coverage Plans pay benefits, the rules for determining the order of payment are as follows:

- A. The Primary Coverage Plan pays or provides its benefits as if the Secondary Coverage Plan or Coverage Plans did not exist.
- B. A Coverage Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide out-of-network benefits.
- C. A Coverage Plan may consider the benefits paid or provided by another Coverage Plan in determining its benefits only when it is secondary to that other Coverage Plan.
- D. The first of the following rules that describes which Coverage Plan pays its benefits before another Coverage Plan is the rule to use.
 1. Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Coverage Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage Plan covering the person as a dependent; and

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primary to the Coverage Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Coverage Plan is primary.

2. Child Covered Under More Than One Coverage Plan. The order of benefits when a child is covered by more than one Coverage Plan is:
 - a. The Primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:
 - 1) The parents are married;
 - 2) The parents are not separated (whether or not they ever have been married); or
 - 3) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.
 - b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or plan years commencing after the Coverage Plan is given notice of the court decree.
 - c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
 - 1) The Coverage Plan of the custodial parent;
 - 2) The Coverage Plan of the spouse of the custodial parent;

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- 3) The Coverage Plan of the noncustodial parent; and then
 - 4) The Coverage Plan of the spouse of the noncustodial parent.
3. Active or inactive employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled D.1.
 4. Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored.
 5. Longer or shorter length of coverage. The Coverage Plan that covered the person as an employee, member, subscriber or retiree longer is primary.
 6. If a husband or wife is covered under this Coverage Plan as a Participant and as an Enrolled Dependent, the dependent benefits will be coordinated as if they were provided under another Coverage Plan, this means the Participant's benefit will pay first.
 7. If the preceding rules do not determine the Primary Coverage Plan, the Allowable Expenses shall be shared equally between the Coverage Plans meeting the definition of Coverage Plan

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under this provision. In addition, this Coverage Plan will not pay more than it would have paid had it been primary.

- E. A group or individual automobile contract that provides medical, no-fault or personal injury protection benefits or a homeowner's policy that provides medical benefits coverage shall provide primary coverage.

Effect on the Benefits of this Plan When Medicare is the other Coverage Plan

- A. When this Coverage Plan is secondary, it may reduce its benefits by the total amount of benefits paid or provided by all Coverage Plans Primary to this Coverage Plan. As each claim is submitted, this Coverage Plan will:
 1. Determine its obligation to pay or provide benefits under its contract;
 2. Determine the difference between the total Allowable Expenses and the benefit payments that the Primary Coverage Plan(s) paid.

If there is a difference between the total Allowable Expenses and the benefit payments that the Primary Coverage Plan(s) paid, this Coverage Plan will pay that amount, less any applicable deductible and coinsurance requirement of this Coverage Plan.
- B. If a Covered Person is enrolled in two or more closed panel Coverage Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel Coverage Plan, COB shall not apply between that Coverage Plan and other closed panel Coverage Plans.
- C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

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

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

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.

Effect on the Benefits of this Plan When any other Plan is the other Coverage Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to

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

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

Right to Receive and Release Needed Information

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

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

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Payments Made

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

Right of Recovery

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

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Section 8: When Coverage Ends

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

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

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

General Information about When Coverage Ends

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

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

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

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Events Ending Your Coverage

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

Ending Event	What Happens
The Entire Plan Ends	Your coverage ends on the date the Plan ends. We are responsible for notifying you that your coverage has ended.
You Are No Longer Eligible	Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Participant, your coverage ends at the end of the calendar year in which you are no longer eligible to be an Enrolled Dependent. Please refer to (Section 10: Glossary of Defined Terms) for a more complete definition of the terms "Eligible Person", "Participant", "Dependent" and "Enrolled Dependent".
The Claims Administrator Receives Notice to End Coverage	Your coverage ends on the last day of the calendar month in which the Claims Administrator receives written notice from us instructing the Claims Administrator to end your coverage, or the date requested in the notice, if later.
Participant Retires or Is Pensioned	<p>Your coverage ends the last day of the calendar month in which the Participant is retired or pensioned under the Plan. We are responsible for providing written notice to the Claims Administrator to end your coverage.</p> <p>This provision applies unless we designate a specific coverage classification for retired or pensioned persons, and only if the Participant continues to meet any applicable eligibility requirements. We can provide you with specific information about what coverage is available for retirees.</p>
Failure to Pay	Your coverage ends on the date identified by the Plan Sponsor if you fail to pay a required contribution.

Other Events Ending Your Coverage

When any of the following happen, we will provide prior written notice to the Participant that coverage will end on the date identified in the notice if:

Ending Event	What Happens
Fraud, Misrepresentation or False Information	The Participant commits an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include, but are not limited to, false information relating to another person's eligibility or status as a Dependent.
Threatening Behavior	You commit an act of physical or verbal abuse that imposes a threat to our staff, the Claims Administrator's staff, a provider, or other Covered Persons.

Coverage for a Handicapped Child

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

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

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

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

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

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

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Extended Coverage for Full-time Students

Coverage for an enrolled Dependent child who is a Full-time Student at a post-secondary school and who needs a medically necessary leave of absence will be extended until the earlier of the following:

- one year after the medically necessary leave of absence begins; or
- the date coverage would otherwise terminate under the Plan.

Coverage will be extended only when the enrolled Dependent is covered under the Plan because of Full-time Student status at a post-secondary school immediately before the medically necessary leave of absence begins.

Coverage will be extended only when the enrolled Dependent's change in Full-time Student status meets all of the following requirements:

- the enrolled Dependent is suffering from a serious Sickness or Injury;
- the leave of absence from the post-secondary school is medically necessary, as determined by the enrolled Dependent's treating Physician; and
- the medically necessary leave of absence causes the enrolled Dependent to lose Full-time Student status for purposes of coverage under the Plan.

A written certification by the treating Physician is required. The certification must state that the enrolled Dependent child is suffering from a serious Sickness or Injury and that the leave of absence is medically necessary.

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For purposes of this extended provision, the term “leave of absence” shall include any change in enrollment at the post-secondary school that causes the loss of Full-time Student status.

Extended Coverage for Dependent Children

Coverage under this Plan may be extended for a dependent child if the following conditions are met:

- unmarried
- The dependent child was covered by this Plan on the day before the last day of the calendar year in which the child’s 19th birthday occurs, and
- A covered dependent child who is attending high school, a licensed trade school, or an accredited institution of higher education as a full-time student will continue to be eligible until the end of the calendar year in which the child turns age 25 or until the dependent child no longer attends school as a full-time student, whichever is earlier. Extended coverage for dependent children who have not reached age 25 will terminate at the end of the month that the dependent child is no longer attending or enrolled as a full-time student. The Plan will require proof of the dependent child’s full-time Student enrollment on an as-needed basis (per semester/trimester). A full-time student who finishes the spring term shall be deemed a full-time student throughout the summer if the student has enrolled as a full-time student for the following fall term, regardless of whether or not such student enrolls for the summer term.

A dependent child will begin or may re-enroll in the plan on the first of the month after 30 days from the first day of the semester, subject to the plan terms, if the dependent child

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qualifies for extended coverage due to initial or re-enrollment as a full-time student; or

- A dependent who is under 27 years of age who is not eligible for coverage under a group health benefit plan offered by his/her employer and for which the amount of the dependents premium contribution is no greater than the premium amount for his or her coverage as a dependent under the subscriber plan, or
- If you have a dependent child covered under this Plan who is under the age of 19 and totally disabled, either mentally or physically, that child's health coverage may continue beyond the day the child would cease to be a dependent under the terms of this Plan. You must submit written proof that the child is totally disabled within 31 calendar days after the day coverage for the dependent would normally end. The plan may, for two years, ask for additional proof at any time, after which the Plan can ask for proof not more than once a year. Coverage may continue for as long as he or she is deemed to be totally disabled under the terms of the plan, and subject to the following minimum requirements:
 - The Dependent must not be able to hold a self-sustaining job due to the disability; and
 - Proof must be submitted as required; and
 - The employee must still be covered under this Plan.

A totally disabled dependent child older than 19 who loses coverage under this plan may not re-enroll in the Plan under any circumstances.

An active duty dependent will continue to be eligible for coverage if he/she meets one of the following requirements:

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- A full-time student regardless of age
- Not eligible for coverage under a group health plan offered by the employer and for which the amount of the dependent's premium contribution is no greater than the premium amount for his or her coverage as a dependent under the subscribers plan.
- Under age 27 when called to federal active duty in the National Guard or in the reserve component of the U.S. armed forces while the dependent was attending, on a full time basis, an institution of higher education
- If the adult ceases to be a full-time student due to medically necessary leave of absence, then coverage must be continued in accordance with the existing law for continued coverage on students on medical leave, and age is not a factor that would affect when such continued coverage would end

Extended Coverage for Total Disability

Coverage for a Covered Person who is Totally Disabled on the date coverage under the Plan would otherwise terminate will not end automatically. We will temporarily extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid as determined by bargaining agreement.

Continuation of Coverage

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

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Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if we are subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed below, whichever is earlier.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who was covered under the Plan on the day before a qualifying event:

- A Participant.
- A Participant's Enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law.
- A Participant's former spouse.

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Qualifying Events for Continuation Coverage under Federal Law (COBRA)

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

The qualifying events with respect to an employee who is a Qualified Beneficiary are:

- A. Termination of employment, for any reason other than gross misconduct.
- B. Reduction in the Participant's hours of employment.

With respect to a Participant's spouse or dependent child who is a Qualified Beneficiary, the qualifying events are:

- A. Termination of the Participant's employment (for reasons other than the Participant's gross misconduct).
- B. Reduction in the Participant's hours of employment.
- C. Death of the Participant.
- D. Divorce or legal separation of the Participant.
- E. Loss of eligibility by an Enrolled Dependent who is a child.
- F. Entitlement of the Participant to Medicare benefits.
- G. The Plan Sponsor's commencement of a bankruptcy under Title 11, United States Code. This is also a qualifying event for any retired Participant and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

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Notification Requirements and Election Period for Continuation Coverage under Federal Law (COBRA)

Notification Requirements for Qualifying Event

The Participant or other Qualified Beneficiary must notify the Plan Administrator within 60 days of the latest of the date of the following events:

- The Participant's divorce or legal separation, or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent.
- The date the Qualified Beneficiary would lose coverage under the Plan.
- The date on which the Qualified Beneficiary is informed of his or her obligation to provide notice and the procedures for providing such notice.

The Participant or other Qualified Beneficiary must also notify the Plan Administrator when a second qualifying event occurs, which may extend continuation coverage.

If the Participant or other Qualified Beneficiary fails to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Participant is continuing coverage under federal law, the Participant must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Notification Requirements for Disability Determination or Change in Disability Status

The Participant or other Qualified Beneficiary must notify the Plan Administrator as described under "Terminating Events for

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Continuation Coverage under Federal Law (COBRA)," subsection A. below.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Attachment II to this Summary Plan Description. The contents of the notice must be such that the Plan Administrator is able to determine the covered employee and Qualified Beneficiary or Qualified Beneficiaries, the qualifying event or disability, and the date on which the qualifying event occurred.

None of the above notice requirements will be enforced if the Participant or other Qualified Beneficiary is not informed of his or her obligations to provide such notice.

After providing notice to the Plan Administrator, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation coverage must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the Plan Administrator.

The Qualified Beneficiary's initial premium due to the Plan Administrator must be paid on or before the 45th day after electing continuation.

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect

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COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Participant must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Participant will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

Terminating Events for Continuation Coverage under Federal Law (COBRA)

Continuation under the Plan will end on the earliest of the following dates:

- A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Participant's employment was terminated or hours were reduced (i.e., qualifying events A and B).

If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at any time within the first 60 days of continuation coverage for qualifying event A or B, then the Qualified Beneficiary may elect an additional eleven months of continuation coverage (for a total of twenty-nine months of continued coverage) subject to the following conditions:

- Notice of such disability must be provided within the latest of 60 days after:

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- ◆ the determination of the disability; or
- ◆ the date of the qualifying event; or
- ◆ the date the Qualified Beneficiary would lose coverage under the Plan; and
- ◆ in no event later than the end of the first eighteen months.

— The Qualified Beneficiary must agree to pay any increase in the required premium for the additional eleven months.

— If the Qualified Beneficiary who is entitled to the eleven months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional eleven months of continuation coverage.

Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

- B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Participant, divorce or legal separation of the Participant, or loss of eligibility by an Enrolled Dependent who is a child (i.e. qualifying events C, D, or E).
- C. With respect to Qualified Beneficiaries, and to the extent that the Participant was entitled to Medicare prior to the qualifying event:
- Eighteen months from the date of the Participant's Medicare entitlement; or
 - Thirty-six months from the date of the Participant's Medicare entitlement, if a second qualifying event (that was due to either the Participant's termination of employment or

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the Participant's work hours being reduced) occurs prior to the expiration of the eighteen months.

- D. With respect to Qualified Beneficiaries, and to the extent that the Participant became entitled to Medicare subsequent to the qualifying event:
- Thirty-six months from the date of the Participant's termination from employment or work hours being reduced (first qualifying event) if:
 - ◆ The Participant's Medicare entitlement occurs within the eighteen month continuation period; and
 - ◆ Absent the first qualifying event, the Medicare entitlement would have resulted in a loss of coverage for the Qualified Beneficiary under the group health plan.
- E. The date coverage terminates under the Plan for failure to make timely payment of the premium.
- F. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.
- G. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event G). If the Qualified Beneficiary was entitled to continuation because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event G) and the retired Participant dies during the continuation period, then the other Qualified Beneficiaries shall

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be entitled to continue coverage for thirty-six months from the date of the Participant's death.

- H. The date the entire Plan ends.
- I. The date coverage would otherwise terminate under the Plan as described in this section under the heading *Events Ending Your Coverage*.

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Section 9: General Legal Provisions

This section provides you with information about:

- General legal provisions concerning the Plan.

Plan Document

This Summary Plan Description presents an overview of your Benefits. In the event of any discrepancy between this Summary Plan Description and the official Plan Document, the Plan Document shall govern.

Relationship with Providers

The relationships between us, the Claims Administrator, and Network providers are solely contractual relationships between independent contractors. Network providers are not our agents or employees. Nor are they agents or employees of the Claims Administrator. Neither we nor any of our employees are agents or employees of Network providers.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. The credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. Network providers are not our employees or employees of the Claims Administrator; nor do we

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

have any other relationship with Network providers such as principal-agent or joint venture. Neither we nor the Claims Administrator are liable for any act or omission of any provider.

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

We and the Plan Administrator are solely responsible for all of the following:

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

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and us is that of employer and employee, Dependent or other classification as defined in the Plan.

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Incentives to Providers

The Claims Administrator pays Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost effectiveness.
- Capitation - a group of Network providers receives a monthly payment for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

The methods used to pay specific Network providers may vary. From time to time, the payment method may change. If you have questions about whether your Network provider's contract includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact the Claims Administrator at the telephone number on your ID card. They can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes the Claims Administrator may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision

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about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact the Claims Administrator if you have any questions.

Rebates and Other Payments

We and the Claims Administrator may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. We and the Claims Administrator do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copayments.

Interpretation of Benefits

We and the Claims Administrator have sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and Amendments.
- Make factual determinations related to the Plan and its Benefits.

We and the Claims Administrator may delegate this discretionary authority to other persons or entities who provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our sole discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that

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we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Plan

We reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Plan. Plan Amendments and Riders are effective on the date we specify.

Any provision of the Plan which, on its effective date, is in conflict with the requirements of federal statutes or regulations, or applicable state law provisions not otherwise preempted by ERISA (of the jurisdiction in which the Plan is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

Any change or amendment to or termination of the Plan, its benefits or its terms and conditions, in whole or in part, shall be made solely in a written amendment (in the case of a change or amendment) or in a written resolution (in the case of a termination), whether prospective or retroactive, to the Plan, in accordance with the procedures established by us. Covered Persons will receive notice of

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any material modification to the Plan. No one has the authority to make any oral modification to the SPD.

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to Benefits. These errors include, but are not limited to, providing misinformation on eligibility or Benefit coverages or entitlements. It is your responsibility to confirm the accuracy of statements made by us or our designees, including the Claims Administrator, in accordance with the terms of this SPD and other Plan documents.

Information and Records

At times we or the Claims Administrator may need additional information from you. You agree to furnish us and/or the Claims Administrator with all information and proofs that we may reasonably require regarding any matters pertaining to the Plan. If you do not provide this information when we request it, we may delay or deny payment of your Benefits.

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

We and the Claims Administrator have the right to release any and all records concerning health care services which are necessary to

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implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Plan, we, the Claims Administrator, and our related entities may use and transfer the information gathered under the Plan for research and analytic purposes.

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

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

In some cases, we or the Claims Administrator will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Such designees have the same rights to this information as the Plan Administrator.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

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

Medicare Eligibility

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

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

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

Subrogation and Reimbursement

The Plan has a right to subrogation and reimbursement, as defined below.

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Right to Subrogation

The right to subrogation means the Plan is substituted to any legal claims that you may be entitled to pursue for Benefits that the Plan has paid. Subrogation applies when the Plan has paid Benefits for a Sickness or Injury for which a third party is considered responsible, e.g. an insurance carrier if you are involved in an auto accident.

The Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and Benefits the Plan has paid on your behalf relating to any Sickness or Injury caused by any third party.

Right to Reimbursement

The right to reimbursement means that if a third party causes a Sickness or Injury for which you receive a settlement, judgment, or other recovery, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury.

Third Parties

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- The Plan Sponsor.
- Any person or entity who is or may be obligated to provide you with benefits or payments under:
 - Underinsured or uninsured motorist insurance.
 - Medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise).
 - Workers' compensation coverage.

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- Any other insurance carrier or third party administrator.

Subrogation and Reimbursement Provisions

As a Covered Person, you agree to the following:

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- The Plan may enforce its subrogation and reimbursement rights regardless of whether you have been "made whole" (fully compensated for your injuries and damages).
- You will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:
 - Complying with the terms of this section.
 - Providing any relevant information requested.
 - Signing and/or delivering documents at its request.
 - Appearing at medical examinations and legal proceedings, such as depositions or hearings.
 - Obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.

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- If you receive payment as part of a settlement or judgment from any third party as a result of a Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- You will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a Sickness or Injury caused by a third party.
- The Plan's rights will not be reduced due to your own negligence.
- The Plan may file suit in your name and take appropriate action to assert its rights under this section. The Plan is not required to pay you part of any recovery it may obtain from a third party, even if it files suit in your name.
- The provisions of this section apply to the parents, guardian, or other representative of an Enrolled Dependent child who incurs a Sickness or Injury caused by a third party.
- In case of your wrongful death, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs.
- Your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of

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Benefits the Plan has paid relating to any Sickness or Injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.

- If a third party causes you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Covered Person.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if either of the following apply:

- 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 we made exceeded the Benefits under the Plan.

The refund equals the amount we paid in excess of the amount we should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help us 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, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

If you want to bring a legal action against us or the Claims Administrator you must do so within three years from the expiration

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of the time period in which a request for reimbursement must be submitted, or you lose any rights to bring such an action against us or the Claims Administrator.

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

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Section 10: Glossary of Defined Terms

This section:

- Defines the terms used throughout this SPD.
- Is not intended to describe Benefits.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Use Disorder Services on an outpatient or inpatient basis.

Amendment - any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when signed by us or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

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Annual Deductible - the amount you must pay for Covered Health Services in a calendar year before we will begin paying for Benefits in that calendar year.

The actual amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. See the definition of Eligible Expenses below.

Any amount you pay for medical expenses in the last three months of the previous calendar year, that is applied to the previous Annual Deductible, will be carried over and applied to the current Annual Deductible. This carry-over feature applies only to the individual Annual Deductible.

Annual Maximum Benefit – the maximum amount the Plan will pay for Benefits during the calendar year.

Autism Spectrum Disorders - a group of neurobiological disorders that includes *Autistic Disorder, Rbett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder,* and *Pervasive Development Disorders Not Otherwise Specified (PDDNOS).*

Benefits - your right to payment for Covered Health Services that are available under the Plan. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Plan, including this SPD and any attached Riders and Amendments.

Claims Administrator - the company (including its affiliates) that provides certain claim administration services for the Plan.

Congenital Anomaly - a physical developmental defect that is present at birth, and is identified within the first twelve months of birth.

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Copayment - the charge you are required to pay for certain Covered Health Services. A Copayment may be either a set dollar amount or a percentage of Eligible Expenses.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator on our behalf.

Covered Health Service(s) - those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance use disorder, or their symptoms.

A Covered Health Service is a health care service or supply described in (Section 1: What's Covered--Benefits) as a Covered Health Service, which is not excluded under (Section 2: What's Not Covered--Exclusions).

Covered Person - either the Participant or an Enrolled Dependent, but this term applies only while the person is enrolled under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

Custodial Care - services that:

- Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); or
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent criteria: To be considered an eligible Dependent, the following conditions must all be met:

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Spouse

- Legal
- Not covered as an employee under this Plan
- Does NOT allow for coverage if legally separated or divorced

Child

- Natural biologic child, or
- Step child, or
- Legally adopted, or
- Legally placed for adoption as granted by action of federal, state or local governmental agency responsible for adoption administration or a court of law, or
- Legal guardianship as ordered by a court, or
- An alternate recipient under a Qualified Medical Child Support Order.
- Must reside with the employee. The residency requirement does not apply to children who are full-time students living away from home to attend school, to children who reside in an institution, or to children who are enrolled in accordance with a Qualified Medical Child Support Order because of the employee's divorce or separation decree.
- Be dependent upon the employee for at least 50 percent support and maintenance. The financial requirement does not apply to children who:
 - are enrolled in accordance with a Qualified Medical Child Support Order because of the employee's divorce or separation decree.

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- Legally qualify to be claimed on employee or spouse's federal income tax return.
- Not be covered as the dependent of another employee at Racine County.
- Not be on extended active duty in the Armed Forces as allowed by law.
- Unmarried (coverage terminates at the end of the month in which your dependent marries).
- Covered through the end of the calendar year of 19th birthday.
- Covered through the end of the calendar year of 25th birthday, if you provide more than 50 percent support as defined by the US Internal Revenue Code and are full time students in an accredited college, university or trade school.
- Covered through the end of the month in which your dependent ceases to be a full time Student.
- If your dependent is mentally or physically handicapped, coverage may continue beyond the day the child would cease to become a dependent under the terms of this plan.. Written proof must be submitted that the child meets these conditions within 31 days after the coverage would normally end. You may be asked to provide additional proof at any time within the next two years, after which you will only be asked once per year. Coverage will continue as long as the dependent child is:
 - Dependent on you or your spouse for more than half of his or her support and
 - Not able to hold a self sustaining job due to the mental retardation or physical handicap and

- The employee is still covered under the plan.

Note for Retiree Plans: Coverage is limited to those dependents who were participants at the time of retirement except if the following two conditions are all met:

Extended Coverage for Dependents age 19 through 27: The dependent shall be at least age 18 and under age 27. The dependent child is not eligible for coverage under a group health benefit plan offered by his/her employer and for which the amount of the dependents premium contribution is no greater than the premium amount for his or her coverage as a dependent under the subscriber plan. You could see tax implications by adding your Dependent(s), please consult with your tax advisor or Human Resources.

Designated Facility - a facility that has entered into an agreement on behalf of the facility and its affiliated staff with the Claims Administrator or with an organization contracting on its behalf to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Durable Medical Equipment - medical equipment that is all of the following:

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

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- Is appropriate for use in the home.

Eligible Expenses - for Covered Health Services incurred while the Plan is in effect, Eligible Expenses are determined as stated below:

For Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from Network providers, Eligible Expenses are the contracted fee(s) with that provider.
- When Covered Health Services are received from non-Network providers as a result of an Emergency or as otherwise arranged through the Claims Administrator, Eligible Expenses are billed charges unless a lower amount is negotiated.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from non-Network providers, Eligible Expenses are determined, at the Claims Administrator's discretion, based on:
 - Available data resources of competitive fees in that geographic area.
 - Fee(s) that are negotiated with the provider.
 - 50% of the billed charge.
 - A fee schedule that the Claims Administrator develops.
- When Covered Health Services are received from Network providers, Eligible Expenses are the contracted fee(s) with that provider.

Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines. The

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reimbursement policy guidelines are developed, in the Claims Administrator's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

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

Eligible Person - a regular full-time employee of the Plan Sponsor who is scheduled to work at his or her job at least 16 hours per week.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

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

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent - a Dependent who is properly enrolled under the Plan.

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Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, substance use disorder or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time a determination is made regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.
- 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.

If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment) we may, in our discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Full-time Student - a person who is enrolled in and attending, full-time, a recognized course of study or training at one of the following:

- An accredited high school.

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- An accredited college or university.
- A licensed vocational school, technical school, beautician school, automotive school or similar training school.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. You are no longer a Full-time Student at the end of the calendar year during which you graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

You continue to be a Full-time Student during periods of regular vacation established by the institution. If you do not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end as described above.

The Plan may require proof of the Dependent child's Full-Time Student enrollment in high school or an Accredited Institution of Higher Education on an as-needed basis. A Student who finishes the spring term shall be deemed a Student throughout the summer if the Student has enrolled for the following fall term, regardless of whether or not such Student enrolls for the summer term. Extended coverage for Dependent children who have not reached age 25 will terminate at the end of the month that the Dependent child is no longer attending or enrolled as a Full-Time Student. A Dependent will continue to be eligible for coverage under the Policy, if due to a medically necessary leave of absence, he or she ceases to be a full-time student. A student is required to submit documentation and certification of the medical necessity of the leave of absence from the person's attending physician. The Policy is required to be continued only until any of the following occurs: The person advises the Policy that he or she does not intend to return to school full-time. The person becomes employed full-time. The person obtains other health care coverage. The person marries and is eligible for coverage under his or her spouse's health care coverage. The person reaches the age at which coverage as a dependent who is a full-time

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student would otherwise end under the terms and conditions of the Policy. Coverage of the insured through which the person has dependent coverage under the Policy is discontinued or not renewed.

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

Hospital - an institution, operated as required by law, that is both of the following:

- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- Has 24 hour nursing services.

A Hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home, convalescent home or similar institution.

Initial Enrollment Period - the initial period of time, as determined by the Plan Administrator, during which Eligible Persons may enroll themselves and their Dependents under the Plan.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

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

Intensive Outpatient Treatment - a structured outpatient Mental Health or Substance Use Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

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

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

Mental Health/Substance Use Disorder Administrator - the organization or individual, designated by the Claims Administrator, that provides or arranges Mental Health Services and Substance Use Disorder Services for which Benefits are available under the Plan.

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

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with the Claims Administrator's affiliate to participate in the Claims Administrator's Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings

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Program. The Claims Administrator's affiliates are those entities affiliated with them through common ownership or control with the Claims Administrator or with its ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of the Claims Administrator's products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - Benefits for Covered Health Services that are provided by a Network Physician, Network facility, or other Network provider.

Non-Network Benefits - Benefits for Covered Health Services that are provided by a non-Network Physician, non-Network facility, or other non-Network provider.

Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Plan, as determined by us.

Out-of-Pocket Maximum - the maximum amount of Annual Deductible and Copayments you pay every calendar year. Once you reach the Out-of-Pocket Maximum for Network Benefits, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that calendar year. Once you reach Out-of-Pocket Maximum for Non-Network Benefits, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that calendar year.

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Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum, as specified in (Section 1: What's Covered--Benefits) and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.

The following costs will never apply to the Out-of-Pocket Maximum:

- Any charges for non-Covered Health Services;
- Copayments for Covered Health Services available by an optional Rider.
- The amount of any reduced Benefits if you don't notify the Claims Administrator as described in (Section 1: What's Covered--Benefits) under the *Must You Notify the Claims Administrator?* column.
- Charges that exceed Eligible Expenses.
- Any Copayments for Covered Health Services in (Section 1: What's Covered--Benefits) that do not apply to the Out-of-Pocket Maximum.

Even when the Out-of-Pocket Maximum has been reached, you will still be required to pay:

- Any charges for non-Covered Health Services.
- Charges that exceed Eligible Expenses.
- The amount of any reduced Benefits if you don't notify the Claims Administrator as described in (Section 1: What's Covered--Benefits) under the *Must You Notify the Claims Administrator?* column.
- Copayments for Covered Health Services available by an optional Rider.

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- Copayments for Covered Health Services in (Section 1: What's Covered--Benefits) that are subject to Copayments that do not apply to the Out-of-Pocket Maximum.

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

Participant - an Eligible Person who is properly enrolled under the Plan. The Participant is the person (who is not a Dependent) on whose behalf the Plan is established.

Physician - any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - United HealthCare Services, Inc. Choice Plus Plan for Racine County Health Benefit Plan.

Plan Administrator - is Racine County or its designee as that term is defined under ERISA.

Plan Sponsor - Racine County. References to "we", "us", and "our" throughout the SPD refer to the Plan Sponsor.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.

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- Childbirth.
- Any complications associated with Pregnancy.

Residential Treatment Facility - a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- it is established and operated in accordance with applicable state law for residential treatment programs;
- it provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Administrator;
- it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- it provides at least the following basic services in a 24-hour per day, structured milieu:
 - room and board;
 - evaluation and diagnosis;
 - counseling; and
 - referral and orientation to specialized community resources.

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

Rider - any attached written description of additional Covered Health Services not described in this SPD. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Plan except for those that are specifically amended in the Rider.

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

Shared Savings Program - the Shared Savings Program provides access to discounts from the provider's charges when services are rendered by those non-Network providers that participate in that program. The Claims Administrator will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. The Claims Administrator does not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When the Claims Administrator uses the Shared Savings Program to pay a claim, patient responsibility is limited to Copayments calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD does not include Mental Illness or substance use disorder, regardless of the cause or origin of the Mental Illness or substance use disorder.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Spinal Treatment - detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or

related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

Total Disability or Totally Disabled - a Participant's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

Transitional Care - Mental Health Services/Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- supervised living arrangement which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an

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adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Services - services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of 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.)

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.

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we and the Claims Administrator may, in our discretion, determine that an Unproven Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we and the Claims Administrator must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Urgent Care Center - a facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an

unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

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Riders, Amendments, Notices

Attachment I

Attachment II

Attachment

I

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

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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 issuer.

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Attachment II

Patient Protection and Affordable Care Act (“PPACA”)

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator’s network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the toll-free number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator’s network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

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For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the toll-free number on the back of your ID card.

