Evidence of Coverage

Select Plus Point of Service High Option Plan

For

Group Number: 704567
Effective Date: July 1, 2005

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Introduction

We are pleased to provide you with this Evidence of Coverage. This Evidence of Coverage describes your Benefits, as well as your rights and responsibilities, under the Plan.

How to Use this Document

We encourage you to read your Evidence of Coverage and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitation of this Evidence of Coverage 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 Evidence of Coverage 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 Evidence of Coverage 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 Evidence of Coverage and any attachments in a safe place for your future reference.

Please be aware that your Physician does not have a copy of your Evidence of Coverage 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 Evidence of Coverage 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 Evidence of Coverage.

When we use the words "we," "us," and "our" in this document, we are referring to the Plan Sponsor, Montgomery County Public Schools. 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).

Customer Service and Claims Submittal

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

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

Prior Notification: As shown on your ID card.

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

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

Claims Submittal Address:

United HealthCare Insurance Company

PO Box 740800

Atlanta, Georgia 30374-0800

Requests for Review of Denied Claims and Notice of Complaints:

Name and Address For Submitting Requests:

United HealthCare Insurance Company

PO Box 30432

Salt Lake City, Utah 84130-0432

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

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

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, In-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 an Out-of-Network provider.

Accessing Benefits

You can choose to receive either In-Network Benefits or Out-of-Network Benefits. To obtain In-Network Benefits, you may select a Primary Physician who will provide or coordinate all of the Covered Health Services you receive.

You must show your identification card (ID card) every time you request health care services from a In-Network provider. If you do not show your ID card, In-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 In-Network Benefits apply, see (Section 3: Description of In-Network and Out-of-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.
- Are provided to Covered Persons under the Extension of Coverage provision in Section 8.

Coinsurance

Coinsurance is the portion of covered health care costs the Covered Person is financially responsible for, usually according to a fixed percentage. For a complete definition of Coinsurance, see Section 10: Glossary of Defined Terms. Coinsurance amounts are listed on the following pages next to the description for each Covered Health Service.

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 are the amount that we will pay for Benefits, as 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 initially determine on our behalf whether a treatment or supply is a Covered Health Service and how the Eligible Expense will be determined and otherwise covered under the Plan.

When you receive Covered Health Services from In-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 Out-of-Network providers, you are responsible for paying, directly to the Out-of-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, In-Network providers are responsible for notifying the Claims Administrator before they provide these services to you. There are some In-Network Benefits, however, for which you are responsible for notifying the Claims Administrator.

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

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

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

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

Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services before you are eligible to receive Out-of-Network Benefits. For a complete definition of Annual Deductible, see (Section 10: Glossary of Defined Terms).	***In-Network*** No Annual Deductible. ***Out-of-Network*** $200 per Covered Person per calendar year, not to exceed $400 for all Covered Persons in a family.
Out-of-Pocket Maximum	The maximum you pay, out of your pocket, in a calendar year for Coinsurance. For a complete definition of Out-of-Pocket Maximum, see (Section 10: Glossary of Defined Terms).	***In-Network*** No Out-of-Pocket Maximum. ***Out-of-Network*** $1,500 per Covered Person per calendar year. The Out-of-Pocket Maximum does not include the Annual Deductible.
Maximum Plan Benefit	The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Plan.	***In-Network*** No Maximum Plan Benefit. ***Out-of-Network*** No Maximum Plan Benefit.

Benefit Information

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
1. Acupuncture Services	***In-Network***			
Acupuncture services for pain therapy when both of the following are true:	Yes	$5 per visit	No	No
	Out-of-Network			
	Yes	20%	Yes	Yes

1. Acupuncture Services

Acupuncture services for pain therapy when both of the following are true:

- Another method of pain management has failed.
- The service is performed by a provider in the provider's office.

Any combination of In-Network and Out-of-Network Benefits is limited to 20 visits per calendar year.

Examples of pain therapy are:

- Treatment of post operative and chemotherapy pain
- Migraine treatment
- Part of a comprehensive treatment program for chronic pain
- Post operative dental pain.

Notify the Claims Administrator

Please remember that for In-Network and Out-of-Network Benefits you must notify the Claims Administrator before receiving services. When you provide notification, the Claims Administrator will verify that the service is a pain management procedure.

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
2. Ambulance Services - Emergency only Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.	***In-Network*** No	*Ground Transportation:* 0% *Air Transportation:* 0%	No	No
	Out-of-Network No	Same as In-Network	Same as In-Network	Same as In-Network
3. Blood Products All cost recovery expenses for blood, blood products, derivatives, components, biologics, and serums to include autologous Services, whole blood, red blood cells, platelets, plasma, immunoglobulin, and albumin.	***In-Network*** No	0%	No	No
	Out-of-Network No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
4. Bones of Face, Neck and Head Health Services for diagnostic and surgical procedures involving bones or joints of the jaw and facial region to treat conditions caused by congenital or developmental deformity, Sickness or Injury. **Note:** Covered Health Services do not include care or treatment of the teeth or gums, intraoral prosthetic devices or surgical procedures for cosmetic purposes.	***In-Network*** Yes, if admitted	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.		
Notify the Claims Administrator Please remember that for In-Network Benefits, if admitted and Out-of-Network Benefits you must notify the Claims Administrator before receiving services.	***Out-of-Network*** Yes	20%	Yes	Yes
5. Child Wellness Services Coverage includes (a) office visits and related expenses for childhood and adolescent immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control; (b) services for hereditary and metabolic newborn screening and follow-up visits from birth to 4 weeks of age including visits for the collection of samples before 2 weeks of age; (c) universal hearing screening of newborns provided by a hospital before discharge; (d) services for age-appropriate screening tests for tuberculosis, anemia, lead toxicity, hearing and vision, as determined by the American Academy of Pediatrics;	***In-Network*** No	Same as Physician's Office Services, Professional Fees, and Outpatient Diagnostic and Therapeutic Services except that no Copayment applies.		

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
(e) physical examinations, developmental assessments, parental anticipatory guidance and laboratory tests considered necessary by the Physician for Health Services describes in (a), (b) and (d) of this paragraph.	***Out-of-Network*** No	20%	Yes	No
6. Chiropractic Treatment Benefits for Chiropractic Treatment when provided by a Chiropractic Treatment provider in the provider's office. Benefits include diagnosis and related services.	***In-Network*** No	$5 per visit	No	No
	Out-of-Network No	20%	Yes	Yes
7. Chlamydia Screening Test An annual chlamydia screening test for: • Women who are (i) younger than 20 years old who are sexually active, and (ii) At least 20 years old who have Multiple Risk Factors; and • Men who have Multiple Risk Factors. "Multiple risk factors" means having a prior history of a sexually transmitted disease, new or multiple sex partners, inconsistent use of barrier contraceptives, or cervical ectopy.	***In-Network*** No	Same as Physician's Office Services.		
	Out-of-Network No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
8. Treatment of Cleft Lip or Cleft Palate or Both Coverage for orthodontics, oral surgery, and otologic, audiological, and speech therapy/language treatment for an Enrolled Dependent child in connection with cleft lip or cleft palate or both. Services must be provided by or under the direction of a Physician. **Notify the Claims Administrator** Please remember that for In-Network Benefits, if admitted and Out-of-Network Benefits you must notify the Claims Administrator before receiving services.	***In-Network*** Yes, if admitted	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Rehabilitation Services and Outpatient Diagnostic and Therapeutic Services.		
	Out-of-Network Yes	20%	Yes	Yes
9. Clinical Trials and Treatment Studies Coverage for patient costs incurred during participation in clinical trials for prevention, early detection and treatment studies on cancer or treatment of other life-threatening conditions when ordered, provided or arranged by a Physician and authorized in advance by us. The treatment must be conducted in a Phase I, Phase II, Phase III or Phase IV clinical trial.	***In-Network*** Yes, if admitted	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Rehabilitation Services and Outpatient Diagnostic and Therapeutic Services.		

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
The clinical trial must be approved by one of the following: one of the National Institutes of Health (NIH); an NIH cooperative group or a NIH center; the Food and Drug Administration (FDA) in the form of an investigational new drug application; the Federal Department of Veterans Affairs; or an institutional review board of an institution in the State of Maryland that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NIH. Coverage applies only if (1) the facility and personnel providing the treatment are capable of doing so by virtue of their experience, training and volume of patients treated to maintain expertise; (2) there is no clearly superior, noninvestigational treatment alternative; (3) the available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative; and (4) the Covered Person and his/her Physician conclude that participation in the clinical trial would be appropriate. Coverage is provided only for the cost of Health Services that is incurred as a result of the treatment being provided to the Covered Person for purposes of a clinical trial. Coverage is not provided for the cost of nonhealth care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial, costs associated with managing the research associated with the clinical trial, or the cost of any investigational drug or device				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
However, Coverage does include patient cost incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the patient's particular condition, to the extent that the drugs or devise are not paid for by the manufacturer, distributor or provider of that drug or device. **Notify the Claims Administrator** Please remember that for In-Network Benefits you must notify the Claims Administrator before receiving services.	***Out-of-Network*** Not covered	Not covered	Not covered	Not covered
10. Dental Services - Accident only Dental services when all of the following are true: • Treatment is necessary because of accidental damage. • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D.". The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident.	***In-Network*** Yes, required before follow up treatment begins.	0%	No	No
Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was: • A virgin or unrestored tooth, or • A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy,	***Out-of-Network*** Yes, required before follow up treatment begins.	Same as In-Network	Same as In-Network	Same as In-Network

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

is not a dental implant, crown or veneer and functions normally in chewing and speech.

Dental services for final treatment to repair the damage must be both of the following:

- Started within three months of the accident.
- Completed within 12 months of the accident.

Please note that dental damage that occurs as a result of normal activities of daily living, not limited to chewing or biting or as a result of poor hygiene 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.

Notify the Claims Administrator

Please remember that for In-Network and Out-of-Network Benefits you must notify the Claims Administrator before receiving follow-up treatment.

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
11. Dental Services - Hospital and Alternate Facility Health Services Related to Dental Care Anesthesia and related charges for dental services performed in a Hospital or Alternate Facility when the dentist and the Physician determine that such services are necessary for the safe and effective treatment of a dental condition. Such treatment is limited to a Covered Person who: • Is a child under 7 years of age; or • Is developmentally disabled; or; • Has one or more physical or mental conditions that require admission to a Hospital or Alternate Facility and general anesthesia for successful dental treatment.Is an individual for whom a superior result can be expected from dental care provided under general anesthesia. • Is an emotionally disturbed child 17 years of age or younger with severe dental problems requiring immediate treatment. Such Health services must be provided under the direction of a Physician or dentist. Coverage does not include expenses for the diagnosis or treatment of dental disease.	***In-Network*** Yes	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Diagnostic and Therapeutic Services.		

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Notify the Claims Administrator Please remember that for In-Network and Out-of-Network Benefits you must notify the Claims Administrator before receiving services.	***Out-of-Network*** Yes	20%	Yes	Yes
12. Diabetes Treatment Coverage for diabetic equipment, diabetes supplies and in-person outpatient diabetic self-management training and education programs (including medical nutrition therapy) when provided under the direction of a Physician by a certified, registered or licensed health care professional. Diabetes self-management training includes training provided to a Covered Person after the initial diagnosis of diabetes or pregnancy induced elevated blood glucose levels in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies. Coverage is also provided for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-management regime, and periodic continuing education training as warranted by the development of new techniques and treatment for diabetes.	***In-Network*** No ***Out-of-Network*** No	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services and Durable Medical Equipment. Same as In-Network	 Same as In-Network	 Same as In-Network

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
13. Durable Medical Equipment	***In-Network*** Yes, for items more than $1,000.	0%	No	No
	Out-of-Network Yes, for items more than $1,000.	20%	Yes	Yes

13. Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use.
- Is Medically Necessary.
- Not consumable or disposable.
- Not of use to a person in the absence of a disease or disability.

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

Examples of Durable Medical Equipment include:

- 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 are considered Durable Medical Equipment and are a Covered

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Health Service. Dental braces are 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). • Shoe orthotics with an appropriate medical diagnosis and two replacement pairs in a calendar year after the initial orthotic. The Claims Administrator will decide if the equipment should be purchased or rented. To receive In-Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor the Claims Administrator identifies. **Notify the Claims Administrator** Please remember that for In-Network and Out-of-Network Benefits you must notify the Claims Administrator before obtaining any single item of Durable Medical Equipment that costs more than $1,000 (either purchase price or cumulative rental of a single item).				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
14. Emergency Health Services 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. You will find more information about Benefits for Emergency Health Services in (Section 3: Description of In-Network and Out-of-Network Benefits). **Notify the Claims Administrator** Please remember that if you are admitted to a In-Network or Out-of-Network Hospital as a result of an Emergency, you must notify the Claims Administrator within one business day or the same day of admission, or as soon as reasonably possible. If you don't notify the Claims Administrator, Benefits for Out-of-Network Hospital Inpatient Stay will be reduced by 20% of Eligible Expenses. Benefits will not be reduced for the outpatient Emergency Health Services.	***In-Network*** Yes if admitted	$50 per visit Waived if admitted.	No	No
	Out-of-Network Yes if admitted	Same as In-Network	Same as In-Network	Same as In-Network

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
15. Enteral Formulas	***In-Network***			
Including medical foods and low protein modified food products when prescribed and administered by a Physician for the treatment of inherited metabolic diseases caused by an inherited abnormality of body chemistry. "Low protein modified food product" means a food product that is: • specially formulated to have less than 1 gram of protein per serving; and • intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease. "Low protein modified food product" does not include a natural food that is naturally low in protein. "Medical food" means a food that is: • intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and formulated to be consumed or administered enterally under the direction of a physician.	No	Same as Physician's Office Services, Professional Fees, and Outpatient Diagnostic and Therapeutic Services.		
	Out-of-Network			
	No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
16 Hearing Aids – Minor Children Nondisposable hearing aids for minor children (from birth to 18 years of age) if the hearings aids are prescribed, fitted and dispensed by a licensed audiologist. An insured or enrolled individual may choose a hearing aid that is priced higher than the benefit payable under the policy or contract and may pay the difference between the price of the hearing aid and the benefit payable, without financial or contractual penalty to the provider of the hearing aid. Any combination of In-Network and Out-of-Network benefits are limited to $1,400 per hearing aid for each hearing impaired ear every 36 months.	***In-Network*** No	0%	No	No
Notify the Claims Administrator Please remember that for Out-of-Network Benefits you must notify the Claims Administrator before receiving services.	***Out-of-Network*** Yes	20%	Yes	No

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
17. Habilitative Services Except for Habilitative Services provided in early intervention and school services, Habilitative Services for children 0-19 years old. See Section 10 - Glossary for a definition of Habilitative Services.	***In-Network*** No	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Rehabilitation Services and Outpatient Surgery, Diagnostic and Therapeutic Services.		
Notify the Claims Administrator Please remember that for Out-of-Network Benefits you must notify the Claims Administrator before receiving services.	***Out-of-Network*** Yes	20%	Yes	Yes
18. Home Health Care Services received from a Home Health Agency that are both of the following: • Ordered by a Physician. • Provided by or supervised by a registered nurse in your home.	***In-Network*** No	0%	No	No
Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required. Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true: • It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified	***Out-of-Network*** Yes	10%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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 or for convenience of patient or patient's family. Home Health Care services are available for the following: • One home visit scheduled to occur within 24 hours after discharge from the hospital or outpatient health care facility for a patient who receives less than 48 hours of inpatient hospitalization following a mastectomy or the surgical removal of a testicle, or who undergoes such procedures on an outpatient basis. We shall provide coverage for an additional home visit if prescribed by the patient's attending physician. • One home visit and an additional home visit when prescribed by a Physician for a mother and newborn child following discharge from a Hospital prior to the 48 or 96 hour limits described below under Maternity Services. Such newborn home visits are not subject to the payment of Copayments, Deductibles or Coinsurance.				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• One home visit when prescribed by a Physician for a mother and newborn child following discharge from a Hospital after the 48 or 96 hour limits described below under Maternity Services. Such home visits shall be provided with the following conditions: • They will comply with generally accepted standards of nursing practice for home care of a mother and newborn child; • They will be provided by a registered nurse with at least 1 year of experience in maternal and child health nursing or community health nursing with an emphasis on maternal and child health; and • They will include any services required by the attending Health Care Provider. 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. Any combination of In-Network and Out-of-Network Benefits is limited to 40 visits per calendar year. One visit equals four hours of skilled care services.				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Notify the Claims Administrator Please remember that for Out-of-Network Benefits you must notify the Claims Administrator before receiving services.				
19. 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.	***In-Network*** No	0%	No	No
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. Any combination of In-Network and Out-of-Network Benefits is limited to 360 days during the entire period of time you are covered under the Plan.	***Out-of-Network*** Yes	10%	Yes	Yes
Notify the Claims Administrator Please remember that for Out-of-Network Benefits you must notify the Claims Administrator before receiving services.				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
20. Hospital - Inpatient Stay Inpatient Stay in a Hospital. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds).	***In-Network*** Yes	0%	No	No
Notify the Claims Administrator Please remember that for In-Network and Out-of-Network Benefits you must notify the Claims Administrator as follows: • For elective admissions: five business days before admission. • For non-elective admissions: within one business day or the same day of admission. • For Emergency admissions: within one business day or the same day of admission, or as soon as is reasonably possible. If you don't notify the Claims Administrator, Out-of-Network Benefits will be reduced by 20% of Eligible Expenses.	***Out-of-Network*** Yes	10% Limited to 180 days per Calendar year.	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
21. Infertility Services Services for the treatment of infertility when provided by or under the direction of a Physician. See In-Vitro Fertilization for specific benefit information.	***In-Network*** No	0%	No	No
	Out-of-Network No	20%	Yes	Yes
22. In-Vitro Fertilization Benefits for outpatient expenses for the treatment of infertility through the use of in-vitro fertilization procedures. This benefit is available if: • The patient's oocytes are fertilized with the sperm of the patient's spouse. • The patient and the patient's spouse have a history of infertility of at least 2 years duration or a diagnosis of infertility associated with any of the following medical conditions: (a) endometriosis (b) exposure before birth to diethylstilbestrol, commonly known as DES (c) blockage of or surgical removal of one or both fallopian tubes or (d) abnormal male factors, including oligospermia, contributing to the infertility.	***In-Network*** Yes	0%	No	No

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• The patient has been unable to conceive through less costly infertility treatments covered under the Plan. • The in-vitro fertilization procedures are performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in-vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in-vitro fertilization.				
Any combination of In-Network and Out-of-Network Benefits is limited to three in-vitro fertilization attempts per live birth, subject to a Lifetime maximum of $100,000.	***Out-of-Network*** Yes	20%	Yes	Yes
Notify the Claims Administrator Please remember that for In-Network and Out-of-Network Benefits you must notify the Claims Administrator before receiving services.				
23. Injections received in a Physician's Office Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.	***In-Network*** No	$5 per visit No Copayment applies when a Physician charge is not assessed.	No	No

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
	Out-of-Network No	20% per injection 10% per allergy injections	Yes	Yes

24. Mammography

Benefits for mammography testing that is consistent with the recommendations of the governmental scientific agencies. Benefits for mammography testing are payable when mammography testing is performed as follows:

- A baseline mammogram for women 35 to 39 years of age;
- A mammogram every 2 years, or more frequently if recommended by a physician, for women who are 40 to 49 years old; and
- An annual mammogram for women 50 years of age or older.

	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
In-Network	No	Same as Physician's Office Services and Outpatient Diagnostic and Therapeutic Services except that no Deductible applies.		
Out-of-Network	No	10%	Yes	No

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

25. Maternity Services

	In-Network			
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. There are special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the programs. To sign up, you should notify the Claims	Yes if past 48 hours following a normal vaginal delivery and 96 hours following a cesarean section delivery.	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.		
Administrator during the first trimester, but no later than one month prior to the anticipated childbirth. We will pay Benefits for an Inpatient Stay of at least: • 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. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. Whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the hospital, the insurer or nonprofit health		$5 Copayment. No Copayment applies to Physician office visits for prenatal care after the first visit.		

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
service plan shall pay the cost of additional hospitalization for the newborn for up to 4 days. **Notify the Claims Administrator** Please remember that for Out-of-Network Benefits you must notify the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described. If you don't notify the Claims Administrator that the Inpatient Stay will be extended, your Benefits for the extended stay will be reduced by 20% of Eligible Expenses.	***Out-of-Network*** Yes	10%	Yes	Yes
26. Mental Health and Substance Abuse Services - Outpatient Mental Health Services and Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including: • Mental health, substance abuse and chemical dependency evaluations and assessment. • Diagnosis. • Treatment planning. • Referral services. • Medication management. • Short-term individual, family and group therapeutic services	***In-Network*** Yes, you must call UBH who will authorize benefits.	0% for visits 1 through 5. 20% for visits 6 or higher	No	No

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
(including intensive outpatient therapy). • Crisis intervention and Residential crisis services, if medically necessary. An office visit to a physician or other health care provider for medication management will not be counted against the number of visits shown in the Your Coinsurance Amount Column. For In-Network Benefits, referrals to a Mental Health/Substance Abuse provider are at the sole discretion of United Behavioral Health, who is responsible for coordinating all of your care. Contact United Behavioral Health regarding In-Network Benefits for outpatient Mental Health and Substance Abuse Services.	***Out-of-Network*** No	20% for visits 1 through 30. 50% for visits 31 or higher	Yes	Yes
27. Mental Health and Substance Abuse Services - Inpatient and Intermediate Mental Health Services and Substance Abuse Services received on an inpatient or intermediate care basis in a Hospital or an Alternate Facility including Residential Crisis Services. Benefits include detoxification from abusive chemicals or substances that is limited to physical detoxification when necessary to protect your physical health and well-being.	***In-Network*** You must call the Mental Health/ Substance Abuse United Behavioral Health to receive the Benefits.	0%	No	No

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
The Mental Health/Substance Abuse United Behavioral Health, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. At the discretion of the Mental Health/Substance Abuse United Behavioral Health, two sessions of intermediate care (such as partial hospitalization) may be substituted for one inpatient day. In-Network Benefits for Mental Health Services and Substance Abuse Services must be provided by or under the direction of United Behavioral Health. For In-Network Benefits, referrals to a Mental Health/Substance Abuse provider are at the sole discretion of United Behavioral Health, who is responsible for coordinating all of your care. Contact the United Behavioral Health regarding Benefits for inpatient/intermediate Mental Health Services and Substance Abuse Services. **Authorization Required** Please remember that you must call and get authorization to receive these Benefits in advance of any treatment through the Mental Health/Substance Abuse United Behavioral Health. The Mental Health/Substance Abuse United Behavioral Health phone number appears on your ID card. Without authorization benefits will be reduced by 20% of Eligible Expenses. Out-of-Network services are limited to 180 days per Calendar Year.	***Out-of-Network*** You must call the Mental Health/ Substance Abuse United Behavioral Health to receive the Benefits.	0%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
28. Morbid Obesity Treatment Treatment of Morbid Obesity through gastric by-pass surgery or another surgical method that is: • recognized by the National Institutes of Health as effective for the long-term reversal of Morbid Obesity; and • consistent with criteria approved by the National Institutes of Health. **Notify the Claims Administrator** Please remember that for In-Network Benefits and Out-of-Network Benefits you must notify the Claims Administrator before receiving services.	***In-Network*** Yes	Same as Physician's Office Services, Hospital-Inpatient Stay, Outpatient Surgery, Diagnostic and Therapeutic Services and Professional Fees for Surgical and Medical Services.		
	Out-of-Network Yes	20%	Yes	Yes
29. Ostomy Supplies Benefits for ostomy supplies include only the following: • Pouches, face plates and belts. • Irrigation sleeves, bags and catheters. • Skin barriers. Benefits are not available for gauze, adhesive, adhesive remover, deodorant, pouch covers, or other items not listed above.	***In-Network*** No	0%	No	No
	Out-of-Network No	20%	Yes	Yes

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

30. Outpatient Surgery, Diagnostic and Therapeutic Services

Outpatient Surgery Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.	***In-Network*** No	0%	No	No
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 *Professional Fees for Surgical and Medical Services*.	***Out-of-Network*** No	10%	Yes	Yes
When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.				
Outpatient Diagnostic Services Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including: • Lab and radiology/X-ray. • Mammography testing as described in Section 23. • Coverage is also provided for bone mass measurement for the prevention, diagnosis and treatment of osteoporosis when the	***In-Network*** No	0%	No	No

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
bone mass measurement is requested by a Physician, and (a) you are at risk for osteoporosis; or (b) you show a specific sign suggestive of spinal osteoporosis and are a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease; or (c) you are receiving long-term glucocorticoid (steroid) therapy; or (d) you have hyperparathyroidism; or (e) you are being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy. 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 *Physician's Office Services* below. This section does not include Benefits for CT scans, Pet scans, MRIs, or nuclear medicine, which are described immediately below.	***Out-of-Network*** No	10%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine Covered Health Services for CT scans, Pet scans, MRI, and nuclear medicine received on an outpatient basis at a Hospital or Alternate Facility.	***In-Network*** No	0%	No	No
Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.	***Out-of-Network*** No	10%	Yes	Yes
Outpatient Therapeutic Treatments 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.	***In-Network*** No	0%	No	No
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 *Physician's Office Services* below.	***Out-of-Network*** No	10%	Yes	Yes

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

31. Physician's Office Services

Covered Health Services for the Diagnosis and treatment for a Sickness of Injury and for Preventive medical care received in a Physician's office.

- Preventive medical care.
- Voluntary family planning.
- Well-baby and well-child care in addition to Child Wellness Services.
- Routine physical examinations.
- Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment.)
- Immunizations.
- Colorectal Cancer screenings
- Insertion or removal of any contraceptive drug or device and associated medically necessary examination.
- Growth Hormone therapy (Office visit only. Injectables and medication covered under Prescription Drug vendor).
- Pap smears.

	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
In-Network	No	$5 per visit No Copayment applies when no Physician charge is assessed.	No	No
Out-of-Network	No	20% No Benefits for preventive care, except for Child preventive care up until age 19 including immunizations, (No deductible applies).	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
32. Private Duty Nursing Private duty nursing care given on an outpatient basis by a licensed nurse (R.N., L.P.N., or L.V.N.) **must be medically necessary**. In-Network and Out-of-Network services combined are Limited to $10,000 per calendar year **Notify the Claims Administrator** Please remember that for Out-of-Network Benefits you must notify the Claims Administrator before receiving services.	***In-Network*** No ***Out-of-Network*** Yes	 0% 20%	 No Yes	 No Yes
33. Professional Fees for Surgical and Medical Services 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. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.	***In-Network*** No ***Out-of-Network*** No	 0% 10%	 No Yes	 No Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
34. Prostate Cancer Screening Coverage is provided for the responses incurred in conducting a medically recognized diagnostic examination which shall include digital rectal exams and prostate-specific antigen (PSA) blood tests for: • for male Covered Persons who are between 40 and 75 years of age. • when used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment, or • when used for staging in determining the need for a bone scan in patients with prostate cancer, or. • when used for Covered Persons who are at high risk for prostate cancer.	***In-Network*** No	Same as Physician's Office Services and Outpatient Diagnostic and Therapeutic Services.		
	Out-of-Network No	20%	Yes	Yes
35. Prosthetic Devices Prosthetic devices that replace a limb or body part including: • Artificial limbs – 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.	***In-Network*** No	0%	No	No

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• A single hair prosthesis for loss of natural hair resulting from chemotherapy or radiation treatment for cancer when prescribed by a resident oncologist. Hair Prosthesis is limited to a $350 Lifetime Maximum. If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device. The prosthetic device must be ordered or provided by, or under the direction of a Physician. Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every calendar year.	***Out-of-Network*** No	20%	Yes	Yes
36. Reconstructive Procedures 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.	***In-Network*** Yes	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.		

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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. Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy related to breast cancer, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact the Claims Administrator at the telephone number on your ID card for more information about Benefits for mastectomy-related services. **Notify the Claims Administrator** Please remember that for In-Network and Out-of-Network Benefits you must notify the Claims Administrator before receiving services.	***Out-of-Network*** Yes	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.		

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

37. Rehabilitation Services - Outpatient Therapy

Short-term outpatient rehabilitation services for:

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.

Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician.

Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within three months of the start of treatment.

Please note that we will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, Strokes or a Congenital Anomaly.

	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
In-Network	No	$5 per visit	No	No
Out-of-Network	No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Any combination of In-Network and Out-of-Network Benefits is limited as follows: • 90 visits of physical therapy per calendar year. • 90 visits of occupational therapy per calendar year. • 90 visits of speech therapy per calendar year. • 90 visits of pulmonary rehabilitation therapy per calendar year. • 90 visits of cardiac rehabilitation therapy per calendar year.				
38. Reproduction Services Coverage provided for the following Reproduction services include: • Voluntary sterilization. • Health services and associated expenses for elective abortion. • Contraceptive supplies and services. • Fetal reduction surgery. • Health services associated with the use of non-surgical or drug-induced Pregnancy termination.	***In-Network*** No	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay and Outpatient Diagnostic and Therapeutic Services.		
	Out-of-Network No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
39. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). Any combination of In-Network and Out-of-Network Benefits is limited to 60 days per calendar year. 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.	***In-Network*** Yes	0%	No	No
Notify the Claims Administrator Please remember that for In-Network and Out-of-Network Benefits you must notify the Claims Administrator before receiving services.	***Out-of-Network*** Yes	10%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
40. Transplantation Services Covered Health Services for the following organ and tissue transplants when ordered by a Physician. For In-Network Benefits, transplantation services must be received at a Designated Facility. Benefits are available for the transplants listed below when the transplant meets the definition of a Covered Health Service, and is not an Experimental, Investigational or Unproven Service:	***In-Network*** Yes	0%	No	No
• Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. • Heart transplants. • Heart/lung transplants. • Lung transplants. • Kidney transplants. • Kidney/pancreas transplants. • Liver transplants. • Liver/small bowel transplants. • Pancreas transplants. • Small bowel transplants.	***Out-of-Network*** Yes	20% Benefits are limited to $30,000 per transplant.	Yes	Yes

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

Benefits are also available for cornea transplants that are provided by a Physician at a Hospital. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive In-Network Benefits.

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

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

Transportation and Lodging

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

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

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Eligible Expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people. • Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Designated Facility. • If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the $100 per diem rate. There is a combined overall lifetime maximum Benefit of $10,000 per Covered Person for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures.				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment/ Coinsurance Amount % Copayments are based on a percent of Eligible Expenses	Does Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
41. 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 *Physician's Office Services* earlier in this section.	***In-Network*** No	$5 per visit	No	No
	Out-of-Network No	20%	Yes	No

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.

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- It is the only available treatment for your condition.

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

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.

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6. Devices and computers to assist in communication and speech.

C. Dental

1. Dental care except as described in (Section 1: What's Covered--Benefits) under the heading *Dental Services - Accident Only*
2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
   - Extraction, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.
3. Dental implants.
4. Dental braces except as described in (Section 1: What's Covered-Benefits) under the heading *Treatment.of Cleft Lip or Cleft Palate or both.*
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.
   - Hospital and Alternate Facility Health Services related to Dental Care.
6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly.

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D. Drugs

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

E. Experimental, Investigational or Unproven Services

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

Clinical Trials are included see (Section 1: What's Covered—Benefits).

F. Foot Care

1. Routine foot care (including the cutting or removal of corns and calluses). Foot care will be provided if a medical condition affecting the feet, such as diabetes, is required.
2 Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include the following:
   - Cleaning and soaking the feet.

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— 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:

— Elastic stockings (unless medically necessary and limited to 6 pairs per calendar year).

— Ace bandages.

— Gauze and dressings.

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 Abuse

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

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4. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by United Behavioral Health.
5. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
6. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by United Behavioral Health.
7. Residential treatment services, unless medically necessary.
8. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of United Behavioral Health, are any of the following:

— Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.

— Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.

— Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.

— Not consistent with United Behavioral Health's level of care guidelines or best practices as modified from time to time.

United Behavioral Health may consult with professional clinical consultants, peer review committees or other appropriate

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

I. Nutrition

Except as described in (Section 1: What's Covered-Benefits) under the heading *Diabetes Treatment.*

1. Megavitamin and nutrition based therapy.
2. Nutritional counseling for either individuals or groups.
3. Except as described in (Section 1: What's Covered—Benefits) under the heading Enteral Formulas, enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

J. Physical Appearance

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

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3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
5. Wigs except as described in (Section 1: What's Covered – Benefits) under the heading Prosthetic Devices.

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.

L. Reproduction

1. Surrogate parenting.

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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).
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan.)
3. Health services for transplants involving mechanical or animal organs.
4. Any solid organ transplant that is performed as a treatment for cancer.

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5. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Health Services* in (Section 1: What's Covered--Benefits).

O. Travel

1. Health Services provided in a foreign country are covered at the out-of-network benefit level, unless the treatment is for Urgent Care, Emergency Care, or otherwise specified by the plan.
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. Purchase cost of eye glasses, contact lenses, or hearing aids except as described in (Section 1: What's Covered--Benefits) under the heading *Hearing Aids-Minor Children.*
2. Fitting charge for eye glasses or contact lenses.
3. Eye exercise therapy.
4. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.
5. Routine eye examinations.

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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, sports or camp, travel, employment, insurance, marriage or adoption.
- Related to judicial or administrative proceedings or orders.
- Conducted for purposes of medical research.
- Required to obtain or maintain a license of any type.

3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
4. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends, except as noted in Section 8 under Extension of Coverage.
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 Out-of-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.

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8. Services for the reposition and grinding of temporomandibular joint syndrome (TMJ), when the services are considered to be medical or dental in nature.
9. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.
10. Sex transformation operations.
11. Custodial Care.
12. Domiciliary care.
13. Respite care.
14. Rest cures.
15. Psychosurgery.
16. Treatment of benign gynecomastia (abnormal breast enlargement in males).
17. Medical and surgical treatment of excessive sweating (hyperhidrosis).
18. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
19. Oral appliances for snoring.
20. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
21. Any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply or equipment.
22. Any charge for services, supplies or equipment advertised by the provider as free.
23. Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency.

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24. Any charges prohibited by federal anti-kickback or self-referral statutes.
25. Any additional charges submitted after payment has been made and your account balance is zero.
26. Any charges by a resident in a teaching hospital where a faculty Physician did not supervise services.
27. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, Strokes or a Congenital Anomaly

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Section 3: Description of In-Network and Out-of-Network Benefits

This section includes information about:

- In-Network Benefits.
- Out-of-Network Benefits.
- Emergency Health Services.

In-Network Benefits

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

- Provided by or under the direction of your Physician.
- Emergency Health Services.

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

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

Comparison of In-Network and Out-of-Network Benefits

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

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	In-Network	Out-of-Network
Outpatient Emergency Health Services	Emergency Health Services are always paid as an In-Network Benefit (paid the same whether you are in or out of the Network). That means that if you seek Emergency care at a Out-of-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.	

Selecting a Primary Physician

If you wish to receive In-Network Benefits, you may select a Primary Physician. Your Primary Physician will be responsible for coordinating all Covered Health Services and for ensuring continuity of care.

If you are the custodial parent of an Enrolled Dependent child, you may select a Primary Physician for that child. You may change your Primary Physician by contacting the Claims Administrator at the telephone number shown on your ID card.

Provider Network

The Claims Administrator arranges for health care providers to participate in a Network. In-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.

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

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

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

Care Coordination℠

Your Primary Physician and other In-Network providers are required to notify the Claims Administrator regarding certain proposed or scheduled health services. When your Primary Physician or other In-Network provider notifies the Claims Administrator, they will work together to implement the Care Coordination℠ process and to provide you with information about additional services that are available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy.

If you receive certain Covered Health Services from a In-Network provider, you must notify the Claims Administrator. The Covered Health Services for which notification is required is shown in (Section 1: What's Covered--Benefits). When you notify the Claims

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Administrator, you will receive the Care Coordination services described above.

Designated Facilities and Other Providers

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

In both cases, In-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.

Health Services from Out-of-Network Providers Paid as In-Network Benefits

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

When you receive Covered Health Services through your Primary Physician, we will pay In-Network Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a Out-of-Network provider.

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Out-of-Network Benefits

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

- Provided by a In-Network provider without a referral from your Primary Physician.
- Provided by Out-of-Network providers.

Notification Requirement

You must notify the Claims Administrator before getting certain Covered Health Services from Out-of-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[SM]

When you notify the Claims Administrator as described above, they will work to implement the Care Coordination[SM] process and to provide you with information about additional services that are available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy.

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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.

Whenever possible, you should contact your Primary Physician before receiving Emergency Health Services, and then seek care from the In-Network provider he or she designates.

In-Network Benefits are paid for Emergency Health Services, even if the services are provided by an Out-of-Network provider.

- If you are confined in a Out-of-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 an In-Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the Out-of-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Out-of-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.
- If you are admitted as an inpatient to a In-Network Hospital within 24 hours of receiving treatment for the same condition as an Emergency Health Service, you will not have to pay the Copayment for Emergency Health Services. The Copayment for an Inpatient Stay in a In-Network Hospital will apply instead.

  Note: Please note that the Copayment for Emergency Health Services will not be waived if you have been placed in an observation bed for the purpose of monitoring your condition, rather than being admitted as an inpatient in the Hospital. In this case, the Emergency Copayment will apply instead of the Copayment for an Inpatient Stay.

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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 contact the Plan Administrator 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. In-Network Benefits are available only if you receive Covered Health Services at a In-Network facility under the direction of your Primary Physician.

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Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Eligible Person	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 Subscriber. For a complete definition of Eligible Person and Subscriber, see (Section 10: Glossary of Defined Terms). If both spouses are Eligible Persons under the Plan, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both. Except as we have described in (Section 4: When Coverage Begins), Eligible Persons may not enroll without our written permission.	We determine who is eligible to enroll under the Plan.
Dependent	Dependent generally refers to the Subscriber's spouse and children or Domestic Partner (same sex only). 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). Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan. If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent. Except as we have described in (Section 4: When Coverage Begins), Dependents may not enroll without our written permission.	We determine who qualifies as a Dependent.

When to Enroll and When Coverage Begins

When to Enroll	Who Can Enroll	Begin Date
Initial Enrollment Period The Initial Enrollment Period is the first period of time when Eligible Persons can enroll.	Eligible Persons may enroll themselves and their Dependents.	Coverage begins on the date identified by the Plan Administrator.
Open Enrollment Period	Eligible Persons may enroll themselves and their Dependents.	The Plan Administrator determines the Open Enrollment Period. Coverage begins on the date identified by the Plan Administrator.
New Eligible Persons	New Eligible Persons may enroll themselves and their Dependents.	If enrolled by the 20th of the month Coverage begins on the first day of the month; If enrolled after the 20th of the month, Coverage begins on the first day of the second month.
Adding New Dependents	Subscribers may enroll Dependents who join their family because of any of the following events: • Birth. • Legal adoption. • Placement for adoption. • Marriage. • Legal guardianship.	Coverage begins on the date identified by the Plan Administrator.

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

If You Receive Covered Health Services from a In-Network Provider

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

If You Receive Covered Health Services from a Out-of-Network Provider

When you receive Covered Health Services from an Out-of-Network provider, you are responsible for requesting payment from

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

You must submit a request for payment of Benefits within one year after the date of service. If an Out-of-Network provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied. 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.

If a Subscriber provides written authorization to allow direct payment to a provider, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the Subscriber. We will not reimburse third parties who have purchased or been assigned benefits by Physicians or other providers.

Required Information

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

A. The Subscriber's name and address.

B. The patient's name, age and relationship to the Subscriber.

C. The member number stated on your ID card.

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

- Patient Diagnosis
- Date(s) of service
- Procedure Code(s) and descriptions of service(s) rendered
- Charge for each service rendered

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- Provider of service Name, Address and Tax Identification Number

E. The date the Injury or Sickness began.

F. A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

Payment of Benefits

Through the Claims Administrator, we will make a benefit determination as set forth below. Benefits will be paid to you unless either of the following is true:

A. The provider notifies the Claims Administrator that your signature is on file, assigning benefits directly to that provider.

B. You make a written request for the Out-of-Network provider to be paid directly at the time you submit your claim.

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

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45 day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45 day period, your claim will be denied.

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

Pre-Service Claims

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

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Urgent Claims that Require Immediate Action

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

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

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

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

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

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

Concurrent Care Claims

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

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

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Section 6: Questions 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 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 (How to File a Claim) you 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

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appeal, a Customer Service representative will provide you with the appropriate address of the Claims Administrator.

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

The Customer Service telephone number is shown on your ID card. Customer Service representatives are available to take your call during regular business hours, Monday through Friday.

How to Appeal a Claim Decision

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

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

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

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Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator 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 request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeals Determinations

Pre-Service and Post-Service Claim Appeals

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

For appeals of pre-service claims (as defined in How to File a Claim), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by 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 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 claims, see "Urgent Claim Appeals that Require Immediate Action" below.

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from 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 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 Claim Appeals that Require Immediate Action

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

- The appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a

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written or electronic determination within 72 hours following receipt by the Claims Administrator of your request for review of the determination taking into account the seriousness of your condition.

For urgent 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.

Voluntary External Review Program

If a final determination to deny Benefits is made, you may choose to participate in our voluntary external review program. This program only applies if the decision is based on either of the following:

- Clinical reasons.
- The exclusion for Experimental, Investigational or Unproven Services.

The external review program is not available if the coverage determinations are based on explicit Benefit exclusions or defined Benefit limits.

Contact the Claims Administrator at the telephone number shown on your ID card for more information on the voluntary external review program.

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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

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to the possibility that another Coverage Plan may cover some 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 benefits under group or individual automobile contracts; 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

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rules apply 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. Routine vision care and outpatient prescription drugs are examples of expenses or services that are not allowed. 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 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

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Coverage Plan covering the person as a dependent; and 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;

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2) The Coverage Plan of the spouse of the custodial parent;
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 Subscriber and as an Enrolled Dependent, the dependent benefits will be coordinated as if they were provided under another Coverage Plan, this means the Subscriber's benefit will pay first.

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

Effect on the Benefits of this Plan

A. When this Coverage Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Coverage Plans during a claim determination period are not more than 100 percent of total Allowable Expenses. The difference between the benefit payments that this Coverage Plan would have paid had it been the Primary Coverage Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the Covered Person and used by this Coverage Plan to pay any Allowable Expenses, not otherwise paid during the claim determination period. As each claim is submitted, this Coverage Plan will:
   1. Determine its obligation to pay or provide benefits under its contract;
   2. Determine whether a benefit reserve has been recorded for the Covered Person; and
   3. Determine whether there are any unpaid Allowable Expenses during that claims determination period.

   If there is a benefit reserve, the Secondary Coverage Plan will use the Covered Person's benefit reserve to pay up to 100 percent of total Allowable Expenses incurred during the claims determination period. At the end of the claim determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

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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 benefit payments that this Coverage Plan would have paid had it been the Primary Coverage Plan and the benefit payments paid or provided by all Coverage Plans primary to this Coverage Plan.

   If there is a difference, this Coverage Plan will pay that amount. Benefits paid or provided by this Coverage Plan plus those of Coverage Plans primary to this Coverage Plan may be less than 100 percent of total Allowable Expenses.

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.

   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+Choice (Medicare Part C) plan and receives non-covered services because the person

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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.

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

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we need to apply these rules and determine the benefits payable, your claim for benefits will be denied.

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

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).

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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.

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

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Events Ending Your Coverage

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

Ending Event	What Happens
The Entire Plan Ends	Your coverage ends on the date the Plan ends. 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 Subscriber or Enrolled Dependent. Please refer to (Section 10: Glossary of Defined Terms) for a more complete definition of the terms "Eligible Person", "Subscriber", "Dependent" and "Enrolled Dependent".
The Plan Administrator Receives Notice to End Coverage	Your coverage ends on the last day of the calendar month in which the Plan Administrator receives written notice from the Subscriber or us instructing the Plan Administrator to end your coverage, or the date requested in the notice, if later.

Other Events Ending Your Coverage

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

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

Coverage for a Handicapped Child

Coverage for an unmarried Enrolled Dependent child who is not able to be self-supporting because of mental retardation or a physical handicap will not end just because the child has reached a certain age. 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 Subscriber 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 Plan Administrator with proof of the child's incapacity and dependency prior to age 19. Before the Plan Administrator agrees to this extension of coverage for the child beyond age 23, the Plan Administrator may require that a Physician chosen by us examine the child. We will pay for that examination.

The Plan 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 prior to age 19 of the Plan Administrator's request as described above, coverage for that child will end September 30th following their 23rd birthday.

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Extended Coverage for Total Disability

Coverage for a Covered Person who is Totally Disabled on the date the Subscriber's coverage under the Plan ends will not end automatically. We will temporarily extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.
- Three months from the date coverage would have ended when the entire Plan was terminated.

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.

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.

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

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.

A. Termination of the Subscriber from employment with us, for any reason other than gross misconduct, or reduction of hours; or

B. Death of the Subscriber; or

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C. Divorce or legal separation of the Subscriber; or

D. Loss of eligibility by an Enrolled Dependent who is a child; or

E. Entitlement of the Subscriber to Medicare benefits; or

F. The Plan Sponsor filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Subscriber and his or her Enrolled Dependents. This is also a qualifying event for any retired Subscriber 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.

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

The Subscriber or other Qualified Beneficiary must notify the Plan Administrator within 60 days of the Subscriber's divorce, legal separation or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent. If the Subscriber 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 Subscriber is continuing coverage under Federal Law, the Subscriber must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Continuation 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.

If the Qualified Beneficiary's coverage was terminated due to a qualifying event, then the initial premium due to the Plan

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Administrator must be paid on or before the 45th day after electing continuation.

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 Subscriber's employment was terminated or hours were reduced (i.e., qualifying event A.).

   If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at anytime within the first 60 days of continuation coverage for qualifying event A. then the Qualified Beneficiary may elect an additional 11 months of continuation coverage (for a total of 29 months of continued coverage) subject to the following condition: (i) notice of such disability must be provided within 60 days after the determination of the disability, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months; and (iii) if the Qualified Beneficiary entitled to the 11 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 11 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.

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B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Subscriber, divorce or legal separation of the Subscriber, loss of eligibility by an Enrolled Dependent who is a child (i.e. qualifying events B., C., or D.).

C. For the Enrolled Dependents of a Subscriber who was entitled to Medicare prior to a qualifying event that was due to either the termination of employment or work hours being reduced, eighteen months from the date of the qualifying event, or, if later, 36 months from the date of the Subscriber's Medicare entitlement.

D. The date coverage terminates under the Plan for failure to make timely payment of the premium.

E. 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 preexisting 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.

F. 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 F.).

G. The date the entire Plan ends.

H. 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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If a Qualified Beneficiary is entitled to 18 months of continuation and a second qualifying event occurs during that time, the Qualified Beneficiary's coverage may be extended up to a maximum of 36 months from the date coverage ended because employment was terminated or hours were reduced. If the Qualified Beneficiary was entitled to continuation because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event F.) and the retired Subscriber dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for 36 months from the date of the Subscriber's death. Terminating events B. through G. described in this section will apply during the extended continuation period.

Continuation coverage for Qualified Beneficiaries whose continuation coverage terminates because the Subscriber becomes entitled to Medicare may be extended for an additional period of time. Such Qualified Beneficiaries should contact the Plan Administrator for information regarding the continuation period.

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Section 9: General Legal Provisions

This section provides you with information about:

- General legal provisions concerning your Plan.

Plan Document

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

Relationship with Providers

The relationships between us, the Claims Administrator, and In-Network providers are solely contractual relationships between independent contractors. In-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 In-Network providers.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we pay Benefits. In-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. In-Network providers are not our employees or employees of the Claims Administrator; nor

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

do we have any other relationship with In-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 In-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 In-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 In-Network providers are:

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

The methods used to pay specific In-Network providers may vary. From time to time, the payment method may change. If you have questions about whether your In-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 In-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.

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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 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.

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

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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 any material modification to the Plan. No one has the authority to make any oral modification to the Evidence of Coverage.

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

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 Evidence of Coverage 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 Subscriber'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 implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required to do by

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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 In-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+Choice (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you **should** follow all rules of that plan that require you to seek services from that plan's participating providers. When 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+Choice plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

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Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. If you receive a Benefit payment from the Plan for an Injury caused by a third party, and you later receive any payment for that same condition or Injury from another person, organization or insurance company, we have the right to recover any payments made by the Plan to you. This process of recovering earlier payments is called subrogation. In case of subrogation, you may be asked to sign and deliver information or documents necessary for us to protect our right to recover Benefit payments made. You agree to provide us all assistance necessary as a condition of participation in the Plan, including cooperation and information submitted to or supplied by a workers' compensation, liability insurance carrier, and any medical benefits, no-fault insurance, or school insurance coverage that are paid or payable.

We shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, for the reasonable value of services and Benefits we provided to you from any or all of the following:

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection (these third parties and persons or entities are collectively referred to as "Third Parties").

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You agree as follows:

- To assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- To cooperate with us in protecting our legal rights to subrogation and reimbursement.
- That our rights will be considered as the first priority claim against Third Parties, to be paid before any other of your claims are paid.
- That you will do nothing to prejudice our rights under this provision, either before or after the need for services or benefits under the Plan.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name.
- That regardless of whether or not you have been fully compensated, we may collect from the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, the reasonable value of services provided under the Plan.
- To hold in trust for our benefit under these subrogation provisions any proceeds of settlement or judgment.
- That we shall be entitled to recover reasonable attorney fees from you incurred in collecting proceeds held by you.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval.
- To execute and deliver such documents (including a written confirmation of assignment, and consent to release medical

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records), and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as we may reasonably request from you.

- We will not pay fees, costs or expenses you incur with any claim or lawsuit, without our prior written consent.

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.

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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 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 Evidence of Coverage.
- Is not intended to describe Benefits.

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

- Pre-scheduled surgical services.
- Emergency Health Services.
- Pre-scheduled rehabilitative, laboratory or diagnostic services.

An Alternate Facility may also provide Mental Health Services or Substance Abuse 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

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

subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

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

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 Evidence of Coverage and any attached Riders and Amendments.

Chiropractic 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.

Claims Administrator United Healthcare) - 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.

Coinsurance - the charge you are required to pay for certain Covered Health Services. This is a percentage of Eligible Expenses.

Copayment - the charge you are required to pay for certain Covered Health Services. This is a set dollar amount.

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

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Covered Health Service(s) -those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, 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 Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Plan. References to "you" and "your" throughout this Evidence of Coverage 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 - the Subscriber's legal spouse or an unmarried dependent child of the Subscriber or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Domestic Partner. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.

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- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any unmarried dependent child until September 30th following their 23rd birthday including full-time students only if you furnish evidence upon our request, satisfactory to us, of all the following conditions:
  - The child must not be regularly employed on a full-time basis.
  - The child must be primarily dependent upon the Subscriber for support and maintenance and claimed as an income tax deduction.

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

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

Domestic Partner - a person of the same sex with whom the Subscriber has established a Domestic Partnership.

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Domestic Partnership - a relationship between a Subscriber and one other person of the same sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must share the same permanent residence and the common necessities of life.
- They must be at least 18 years of age.
- They must be mentally competent to consent to contract.
- They must be financially interdependent and they have furnished documents to support at least two of the following conditions of such financial interdependence:
  - They have a single dedicated relationship of at least six months duration.
  - They have joint ownership of a residence.
  - They have at least two of the following:
    - A joint ownership of an automobile.
    - A joint checking, bank or investment account.
    - A joint credit account.
    - A lease for a residence identifying both partners as tenants.
    - A will, retirement and/or life insurance policies which designates the other as primary beneficiary.

The Subscriber and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.

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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.
- Is appropriate for use in the home.

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

- For In-Network Benefits, Eligible Expenses are based on either of the following:
  - When Covered Health Services are received from In-Network providers, Eligible Expenses are the contracted fee(s) with that provider.
  - When Covered Health Services are received from Out-of-Network providers as a result of an Emergency or as otherwise arranged by the Claims Administrator, Eligible Expenses are the fee(s) that are negotiated with the Out-of-Network provider.
- For Out-of-Network Benefits, Eligible Expenses are based on either of the following:
  - When Covered Health Services are received from Out-of-Network providers, the Claims Administrator calculates Eligible Expenses based on available data resources of competitive fees in that geographic area.

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— When Covered Health Services are received from In-Network providers, Eligible Expenses are the contracted fee(s) with that provider.

Eligible Expenses are determined solely in accordance with the Claim Administrator's reimbursement policy guidelines. The reimbursement policy guidelines are developed, in the Claim 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.
- 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 – an active employee of the Plan Sponsor who is scheduled to work at his or her job at least 20 hours per week; or a retiree and or their dependents not eligible for Medicare.

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.

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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.

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

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not 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.

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Habilitative Services – services, including occupational therapy, physical therapy and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. For purposes of Habilitative Services, a congenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. A congenital or genetic birth defect includes, but is not limited to (a) autism or an autism spectrum disorder, and (b) cerebral palsy.

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.

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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.

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

Maximum Plan Benefit - the maximum amount that we will pay for Benefits during the entire period of time that you are enrolled under the Plan, or any other plan of the Plan Sponsor. When the Maximum Plan Benefit applies, it is described in (Section 1: What's Covered--Benefits).

Medicare - Parts A, B, and C 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 Abuse United Behavioral Health - the organization or individual, designated by the Claims Administrator, that provides or arranges Mental Health Services and Substance Abuse Services for which Benefits are available under the Plan.

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

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.

In-Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect with the Claims Administrator or an affiliate (directly or through one or more other organizations) to provide Covered Health Services to Covered Persons.

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

In-Network Benefits - Benefits for Covered Health Services that are provided by or under the direction of your Primary Physician. In-Network Benefits include Emergency Health Services.

Out-of-Network Benefits - Benefits for Covered Health Services that are not provided by or directed by your Primary Physician.

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. We and the Plan Administrator will agree upon the period of time that is the Open Enrollment Period.

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Out-of-Pocket Maximum - the maximum amount of Coinsurance you pay every calendar year. Once you reach the Out-of-Pocket Maximum for Out-of-Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that calendar year.

Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum, as specified in (Section 1: What's Covered--Benefits).

The Out-of-Pocket Maximum does not include any of the following:

- 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.
- The Annual Deductible.

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.

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

Plan - High Option Select Plus for Montgomery County Public Schools Health Benefit Plan.

Plan Administrator - is Montgomery County Public Schools.

Plan Sponsor - Montgomery County Public Schools. References to "we", "us", and "our" throughout the Evidence of Coverage refer to the Plan Sponsor.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Primary Physician – an In-Network Physician that you select to be responsible for providing or coordinating all Covered Health Services (for In-Network Benefits). A Primary Physician has entered into an agreement with the Claims Administrator to provide primary care health services to Covered Persons. The majority of his or her practice generally includes pediatrics, internal medicine, obstetrics/gynecology, or family or general practice.

Reasonable and Customary Charge- an amount measured and determined by the Claims Administrator by comparing the actual charge for the service or supply with the prevailing charges made for it. The Claims Administrator determines the prevailing charge. It takes into account all pertinent factors including:

- The complexity of the service.
- The range of services provided.

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

Rider - any attached written description of additional Covered Health Services not described in this Evidence of Coverage. 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.

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.

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

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

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

Substance Abuse Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse 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

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Association does not mean that treatment of the disorder is a Covered Health Service.

Total Disability or Totally Disabled - a Subscriber'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.

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

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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 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

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are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

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

Group health plans and health insurance issuers generally may not, under Federal law, 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 cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require than a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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