

HANFORD EMPLOYEE WELFARE TRUST (HEWT)

SUMMARY PLAN DESCRIPTION

“UnitedHealthcare PPO” Medical Plan

for

Retired Employees Under 65

Effective Date: January 1, 2014

Medical Claims Administered by UnitedHealthcare

Group Number: 702633

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Introduction

The Hanford Employee Welfare Trust (HEWT) is pleased to provide you with this Summary Plan Description (SPD) which describes your Benefits, as well as your rights and responsibilities, under the Plan as they exist as of January 1, 2014.

You and your dependents are eligible for this Plan if you are an Eligible Person as defined in Section 10: Glossary of Defined Terms, and you are a retiree (or surviving spouse) of a Sponsoring Employer listed in Attachment II or of a predecessor contractor.

This document describes Benefits for two plans:

1. The ***HEWT Options Medical Plan for Retired Employees Under 65*** - applies to all enrolled retired employees under 65 (and their Eligible Dependents) whose homes are located in areas in which UnitedHealthcare network providers are available.
2. The ***HEWT Out-of-Area Medical Plan for Retired Employees Under 65*** - applies to retired employees under 65 (and their Eligible Dependents) whose homes are NOT located in an areas in which UnitedHealthcare network providers are available. This plan will apply in only rare circumstances because the UnitedHealthcare PPO network covers a majority of the United States. UnitedHealthcare can confirm whether this plan applies to you.

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

How to Use This Document

We encourage you to read this SPD and all attached Riders and Amendments carefully. Many of the sections relate to other sections of the document. You may not have all of the information you need by reading just one section. We especially encourage you to review Section 1: What's Covered – Benefits, Section 2: What's Not Covered – Exclusions, and Section 9: General Legal Provisions.

Keep this SPD and other documents related to your Medical Plan in a safe place for future reference.

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

Information About Defined Terms

Because this SPD is a legal document, we want to give you information that will help you better understand it. Certain capitalized words have special meanings. We have defined these words in Section 10: Glossary of Defined Terms. Refer to this section as you read the document to have a better understanding of the SPD and of your Plan.

The words “we,” “us,” and “our” in this document refer to the ***Plan Administrator*** which is the Hanford Employee Welfare Trust (HEWT) or Mission Support Alliance, LLC who is delegated to provide administrative functions on behalf of the HEWT. The words “you” and “your” refer to Retirees and Dependents who are Covered Persons as the term is defined in Section 10: Glossary of Defined Terms.

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Your Contribution Towards Plan Costs

The Plan requires Retirees to contribute towards the cost of the coverage. Contact the Plan Administrator for information about the portion of the Plan cost for which you may be responsible. The contributions you are required to make will be adjusted from time to time by the Plan Administrator in its sole discretion.

Customer Service and Claims Submittal

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

The term *Claims Administrator* refers to UnitedHealthcare. Following are important Claims Administrator department names and toll free telephone numbers:

Customer Service Representative: 1-(866) 249-7606
(questions regarding coverage or claims):

Personal Health Support /Notification: 1-(866) 249-7606

Mental Health/Substance Use Disorder Services:
1-(866) 249-7606

Prescription Drug Program: (Express Scripts): 1-(800) 796-7518

Claims Submittal Address:

UnitedHealthcare - Claims
P.O. Box 30555
Salt Lake City, Utah 84130-0555

Requests for Review of Denied Claims and Notice of Complaints:

Name and Address For Submitting Requests:

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, Utah 84130-0432

Internet:

We also encourage you to visit the Claims Administrator's website, www.myuhc.com, to take advantage of several self-service features including: viewing your claims' status, ordering ID cards and finding Network Physicians in your area.

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Section 1: What's Covered--Benefits

This section provides you with information about:

- Accessing Benefits.
- Copayments and Eligible Expenses.
- Annual Deductible, Out-of-Pocket Maximum and Maximum Plan Benefit.
- Covered Health Services. We pay Benefits for the Covered Health Services described in this section unless they are listed as not covered in Section 2: What's Not Covered--Exclusions.
- Covered Health Services that require you to notify Personal Health Support before you receive them.

Accessing Benefits

Under the Options PPO Plan, you can choose to receive either PPO Network Benefits or PPO Non-Network Benefits. To obtain PPO Network Benefits you must see a Network Physician or other Network provider.

If you qualify for the Out-of-Area Plan, you can choose to receive Benefits from any Physician or provider. Depending on the geographic area, you may have access to Network providers. These providers have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from a Network

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

provider, your Copayment level will remain the same. However, the portion that you owe may be less than if you received services from a non-Network provider because the Eligible Expense may be a lesser amount.

For the PPO Plan, you must show your identification card (ID card) every time you request health care services for you, or for a covered dependent, from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive.

For the Out-of-Area Plan, you should show your identification card (ID card) every time you request health care services so that the provider will know that you are enrolled under the Plan.

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.

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.

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Eligible Expenses

Eligible Expenses are the amount that we will pay for Covered Health Services, incurred while the Plan is in effect, are determined by us or by our designee once you have met your Annual Deductible. In almost all cases our designee is the Claims Administrator, United Healthcare. 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.

For PPO Network Benefits, you are not responsible for any difference between the Eligible Expenses and the amount the provider bills, unless you agreed to reimburse the provider for such services. For PPO Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses and any amounts in excess of any plan maximum.

Notification Requirements

Prior notification is required before you receive certain Covered Health Services. You are responsible for notifying Personal Health Support before you receive these Covered Health Services.

For Mental Health/Substance Use Disorder (MH/SUD) Services you are responsible for notifying the MH/SUD Administrator.

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

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

To notify Personal Health Support or the MH/SUD Administrator, call the toll free telephone number shown on your ID card, 1-866-249-7606, for Claims Administration.

We urge you to confirm with Personal Health Support that the services you plan to receive are Covered Health Services, even if not indicated in the *Must You Notify Personal Health Support?* 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 the toll free telephone number shown on your ID card, 1-866-249-7606, 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 or Investigational Services or Unproven Services exclusion.
- Any other limitation or exclusion of the Plan.

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Special Note Regarding Medicare

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

Special Note Regarding Mental Health and Substance Use Disorder Services

You must provide pre-service notification as described below.

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

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

For a scheduled admission, you must notify the MH/SUD Administrator prior to the admission, or as soon as reasonably possible for non-scheduled admissions (including Emergency

admissions). If you fail to notify the MH/SUD Administrator as required, Benefits may be reduced.

In addition, you must notify the MH/SUD Administrator before the following services are received. If you fail to notify the MH/SUD Administrator as required, Benefits may be reduced. Services requiring prior notification are:

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

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Payment Information

Payment Term	Description	Amounts
Annual Deductible	<p>The amount you pay for Covered Health Services before you are eligible to receive Benefits.</p> <p>For a complete definition of Annual Deductible, see Section 10: Glossary of Defined Terms.</p> <p>The actual amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. For a complete definition of Eligible Expenses, see (Section 10: Glossary of Defined Terms).</p>	<p style="text-align: center;"><u>PPO Network/Out-of-Area</u></p> <p>\$400 per Covered Person per calendar year. Family deductible is met once two Covered Persons each meet the individual deductible. The family deductible is \$800 for all Covered Persons in a family.</p> <p style="text-align: center;"><u>PPO Non-Network</u></p> <p>\$600 per Covered Person per calendar year. Family deductible is met once two Covered Persons each meet the individual deductible. The family deductible is \$1,200 for all Covered Persons in a family.</p> <p>The \$400 PPO Network and \$600 PPO Non-Network individual deductibles cross apply. When the \$400 individual per Covered Person is met, the Covered Person still needs to meet the additional \$200 individual deductible for the PPO Non-Network.</p>
	<p style="text-align: center;"><u>PPO Network/Out-of-Area</u></p> <p>Covered Expenses charged by both Network and non-Network providers apply towards both the Network Individual and Family Deductible and the non-Network Individual and Family Deductible.</p>	

Payment Term	Description	Amounts
Out-of-Pocket Maximum	<p>The maximum you pay, out of your pocket, in a calendar year for Copayments. For a complete definition of Out-of-Pocket Maximum, see Section 10: Glossary of Defined Terms.</p> <p>Note, expenses that are applied towards your annual deductible do not apply towards the annual Out-of-Pocket Maximum.</p>	<p style="text-align: center;"><u>PPO Network/Out-of-Area Plan</u></p> <p>\$2,000 per Covered Person per calendar year. Family is met once two Covered Persons each meet the individual out-of-pocket maximum. The family out-of-pocket maximum is \$4,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible.</p> <p style="text-align: center;"><u>PPO Non-Network</u></p> <p>\$4,000 per Covered Person per calendar year. Family is met once two Covered Persons each meet the individual out-of-pocket maximum. The family out-of-pocket maximum is \$8,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible.</p>
Maximum Plan Benefit	<p>The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Plan. For a complete definition of Maximum Plan Benefit, see Section 10: Glossary of Defined Terms.</p>	<p>\$1,500,000 per Covered Person.</p>

Benefit Information

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
1. Acupuncture Services				
Acupuncture services for pain therapy when the following is true:	<u>PPO Network</u>	20%	Yes	Yes
<ul style="list-style-type: none"> The service is performed by a provider in the provider's office. 	<u>PPO Non-Network</u>	20%	Yes	Yes
Where such Benefits are available, acupuncture is a Covered Health Service for the treatment of:	<u>Out-of-Area</u>	20%	Yes	Yes
<ul style="list-style-type: none"> Nausea of Chemotherapy, or Post-operative nausea, or Nausea of early Pregnancy. 	No	20%	Yes	Yes
Any combination of PPO Network and PPO Non-Network Benefits are limited to 20 visits per calendar year.				
Benefits are limited to 20 visits per calendar year under the Out-of-Area Plan.				

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
2. Ambulance Services - Emergency only	<u>PPO Network</u>	<i>Ground Transportation:</i> 20%	Yes	Yes
Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.	No	<i>Air Transportation:</i> 20%	Yes	Yes
	<u>PPO Non-Network</u>	Same as PPO Network	Yes	Yes
	No	<u>Out-of-Area</u> No	Yes	Yes
	<u>PPO Network</u>	<i>Ground Transportation:</i> 40%	Yes	Yes
3. Ambulance Services - Non-Emergency	No	<i>Air Transportation:</i> 40%	Yes	Yes
Transportation by professional ambulance, other than air ambulance, to and from a medical facility.				
Transportation by regularly-scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the				

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
required treatment.	<u>PPO Non-Network</u> No	Same as PPO Network	Yes	Yes
	<u>Out-of-Area</u> No	Same as PPO Network	Yes	Yes
4. Congenital Heart Disease Services	<u>PPO Network</u>			
Covered Health Services for Congenital Heart Disease (CHD) services when ordered by a Physician. CHD services may be received at a Congenital Heart Disease Resource Services program. Benefits are available for the CHD services when the services meet the definition of a Covered Health Service, and are not an Experimental, Investigational or an Unproven Service.	Designated Facility Only	20%	Yes	Yes
	<u>PPO Non-Network</u> Designated Facility Only	40%	Yes	Yes
Personal Health Support notification is required for all CHD services, including outpatient diagnostic testing, in utero services and evaluation.	<u>Out-of-Area</u> Designated Facility Only	20%	Yes	Yes
<ul style="list-style-type: none"> • Congenital heart disease surgical interventions. • Interventional cardiac catheterization. • Fetal echocardiograms. • Approved fetal interventions. 				
The Copayment and Annual Deductible will not apply to Network Benefits when CHD service is received at a Congenital Heart				

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>Disease Resource Services program. The services described under Transportation and Lodging below are Covered Health Services ONLY in connection with CHD services received at a Congenital Heart Disease Resource Services program.</p> <p>CHD services other than those listed above are excluded from coverage, unless determined by Personal Health Support to be a proven procedure for the involved diagnoses.</p> <p>Contact Personal Health Support at the telephone number on your ID card for information about CHD services.</p> <p style="text-align: center;">Transportation and Lodging</p> <p>Personal Health Support will assist the patient and family with travel and lodging arrangements. Expenses for travel, and lodging for the recipient of CHD services and a companion are available under this Plan as follows:</p> <ul style="list-style-type: none"> • Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of CHD services for the purposes of an evaluation, the procedure or necessary post-discharge follow-up. • Eligible Expenses for lodging 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 CHD recipient resides more than 50 miles from the Congenital Heart Disease Resource Services program. 				

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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- If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging will be reimbursed up to \$100 per diem rate.

There is a combined overall lifetime maximum Benefit of \$10,000 per Covered Person for all transportation, and lodging expenses incurred by the CHD recipient and companion(s) and reimbursed under this Plan in connection with all CHD procedures.

Notify Personal Health Support

You must notify Personal Health Support as soon as CHD is suspected or diagnosed (in utero detection, at birth, or as determined and before the time an evaluation for CHD is performed). **If you don't notify Personal Health Support, Benefits will be reduced to 40% of Eligible Expenses.**

5. 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.

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

<u>PPO Network</u>	20%	Yes	Yes
Yes			
<u>PPO Non-Network</u>	40%	Yes	Yes
Yes			
<u>Out-of-Area</u>	20%	Yes	Yes
Yes			

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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- Dental services related to medical transplant procedures;
- Initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- Direct treatment of acute traumatic Injury, cancer or cleft palate.

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, is not a dental implant 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 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 Personal Health Support

Please remember that you should notify Personal Health Support as soon as possible, but at least five business days before follow-up

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
(post-Emergency) treatment begins. (You do not have to provide notification before the initial Emergency treatment.) When you provide notification, Personal Health Support can verify that the service is a Covered Health Service.				
6. Durable Medical Equipment Durable Medical Equipment that meets each of the following criteria:	<u><i>PPO Network</i></u> Yes, for items more than \$1,000.	20%	Yes	Yes
<ul style="list-style-type: none"> • Ordered or provided by a Physician for outpatient use. • Used for medical purposes. • Not consumable or disposable. • Not of use to a person in the absence of a disease or disability. 	<u><i>PPO Non-Network</i></u> Yes, for items more than \$1,000.	40%	Yes	Yes
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:	<u><i>Out-of-Area</i></u> Yes, for items more than \$1,000.	20%	Yes	Yes
<ul style="list-style-type: none"> • Equipment to assist mobility, such as a standard wheelchair. • A standard Hospital-type bed. • Oxygen concentrator units and the rental of equipment to administer oxygen. • Delivery pumps for tube feedings. • Braces that stabilize an Injured body part are considered Durable Medical Equipment and are a Covered Health Service, including necessary adjustments to shoes to accommodate braces. Braces 				

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage.</p> <ul style="list-style-type: none"> • Mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions. • External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. <p>We provide Benefits for a single unit of Durable Medical Equipment (example one insulin pump) and provide repair for that unit.</p> <p>Benefits are provided for the replacement of a type of Durable Medical Equipment once every three calendar years. At the Claim Administrator's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tube, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three year timeline for replacement.</p> <p>Personal Health Support will decide if the equipment should be</p>				

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>purchased or rented. You must purchase or rent the Durable Medical Equipment from the vendor Personal Health Support identifies. Benefits for the purchase and repair of Durable Medical Equipment are limited to \$50,000 per lifetime.</p> <p style="text-align: center;">Notify Personal Health Support</p> <p>Please remember that you must notify Personal Health Support 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).</p>				
<h3>7. Emergency Health Services</h3>				
<p>Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.</p>	<p><u><i>PPO Network</i></u> Yes, but only for an Inpatient Stay.</p>	<p>\$125 copay per visit plus 20%</p>	<p>No Yes</p>	<p>Yes Yes</p>
<p>You will find more information about Benefits for Emergency Health Services in Section 3: Obtaining Benefits.</p>				
<p style="text-align: center;">Notify Personal Health Support</p> <p>To ensure prompt and accurate payment of your claim as a PPO Network Benefit, notify Personal Health Support within two business days or as soon as possible after you receive outpatient Emergency Health Services at a non-Network Hospital or Alternate Facility.</p>	<p><u><i>PPO Non-Network</i></u> Yes, but only for an Inpatient Stay.</p>	<p>\$125 copay per visit plus 20%</p>	<p>No Yes</p>	<p>Yes Yes</p>
<p>Please remember that if you are admitted to a Hospital as a result of an Emergency, you must notify Personal Health Support within two business days after admission, or as soon as reasonably possible.</p>	<p><u><i>Out-of-Area</i></u> Yes, but only for an Inpatient Stay.</p>	<p>\$125 copay per visit plus 20%</p>	<p>No Yes</p>	<p>Yes Yes</p>

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
If you don't notify Personal Health Support, Benefits for the Hospital Inpatient Stay will be reduced to 40% of Eligible Expenses. Benefits will not be reduced for the outpatient Emergency Health Services.				
8. Hearing Care	<u>PPO Network</u>			
Benefits include one annual routine hearing screening to detect hearing impairment.	No	20%	Yes	Yes
	<u>PPO Non-Network</u>			
Benefits for hearing aids are covered up to \$300 in a 36 month period.	No	40%	Yes	Yes
Please note that Benefits are not available for charges connected to batteries and the replacement of hearing aids.	<u>Out-of-Area</u>			
	No	20%	Yes	Yes
9. Hearing Aids	<u>PPO Network</u>			
The Plan pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.	No	20%	Yes	Yes
	<u>PPO Non-Network</u>			
Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.	No	40%	Yes	Yes
	<u>Out-of-Area</u>			
Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.	No	20%	Yes	Yes
Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are				

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:</p> <ul style="list-style-type: none"> • Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid. • Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. <p>Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every three calendar years.</p> <p>PPO Plan: Any combination of Network Benefits and Non-Network Benefits are limited to \$300 in a 36 month period.</p> <p>Out-of-Area Plan: Benefits are limited to \$300 in a 36 month period.</p>				
10. Home Health Care				
<p>Services received from a Home Health Agency that are both of the following:</p> <ul style="list-style-type: none"> • Ordered by a Physician. • Provided by or supervised by a registered nurse in your home. <p>Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled home health care is required.</p>	<u>PPO Network</u> Yes	20%	Yes	Yes
	<u>PPO Non-Network</u> Yes	40%	Yes	Yes
	<u>Out-of-Area</u> Yes	20%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>Skilled home health care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:</p> <ul style="list-style-type: none"> • It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient. • It is ordered by a Physician. • It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair. • It requires clinical training in order to be delivered safely and effectively. • It is not Custodial Care. <p>Personal Health Support will decide if skilled home health care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.</p> <p>Any combination of PPO Network and PPO Non-Network Benefits are limited to 40 visits per calendar year.</p> <p>Out-of-Area Benefits are limited to 40 visits per calendar year. One visit equals four hours of skilled care services.</p>				

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Notify Personal Health Support				
Please remember that you should notify Personal Health Support five business days before receiving services. If you don't notify Personal Health Support, Benefits will be reduced to 40% of Eligible Expenses.				
11. 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.	<u>PPO Network</u>			
	Yes	0%	N/A	No
	<u>PPO Non-Network</u>			
	Yes	0%	N/A	No
	<u>Out-of-Area</u>			
	Yes	0%	N/A	No
Notify Personal Health Support				
Please remember that you must notify Personal Health Support five business days before receiving services. If you don't notify Personal Health Support, Benefits will be reduced to 40% of Eligible Expenses.				
12. Hospital - Inpatient Stay				
Inpatient Stay in a Hospital. Benefits are available for:	<u>PPO Network</u>			
<ul style="list-style-type: none"> Services and supplies received during the Inpatient Stay. 	Yes	\$250 Copayment plus 20% per Inpatient Stay.	Yes Yes	Yes Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> Room and board in a Semi-private Room (a room with two or more beds). 	<u>PPO Non-Network</u> Yes	40%	Yes	Yes
<p style="text-align: center;">Notify Personal Health Support</p> <p>Please remember that you must notify Personal Health Support as follows:</p>	<u>Out-of-Area</u> Yes	20%	Yes	Yes
<ul style="list-style-type: none"> For elective admissions: five business days before admission. For Emergency admissions (also known as non-elective admissions): within two business days after admission, or as soon as is reasonably possible. 				
<p>If you don't notify Personal Health Support, Benefits will be reduced to 40% of Eligible Expenses.</p>				
<p>13. Injections received in a Physician's Office</p> <p>Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.</p>	<u>PPO Network</u> No	20% per injection	Yes	Yes
	<u>PPO Non-Network</u> No	40% per injection	Yes	Yes
	<u>Out-of-Area</u> No	20% per injection	Yes	Yes
<p>14. Maternity Services</p> <p>Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-</p>	<u>PPO Network</u> Yes if Inpatient Stay exceeds time frames.	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.		

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>related medical services for prenatal care, postnatal care, delivery, and any related complications.</p> <p>There is a special prenatal program to help during Pregnancy. It is completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify Personal Health Support during the first trimester, but no later than one month prior to the anticipated childbirth.</p> <p>We will pay Benefits for an Inpatient Stay of at least:</p> <ul style="list-style-type: none"> • 48 hours for the mother and newborn child following a vaginal delivery. • 96 hours for the mother and newborn child following a cesarean section delivery. <p>These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother earlier than these minimum timeframes.</p>	<p><u>PPO Non-Network</u> Yes if Inpatient Stay exceeds time frames.</p> <p><u>Out-of-Area</u> Yes if Inpatient Stay exceeds time frames.</p>	<p>Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.</p> <p>Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.</p>		
<p align="center">Notify Personal Health Support</p> <p>Please remember that you must notify Personal Health Support 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 Personal Health Support that the Inpatient Stay will be extended, your Benefits for the extended stay will be reduced to 40% of Eligible Expenses.</p>				

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>15. Mental Health Services</p> <p>Mental Health Services include those received on an inpatient basis in a Hospital or Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility. Benefits include the following services provided on either an outpatient or inpatient basis:</p> <ul style="list-style-type: none"> • Diagnostic evaluations and assessment. • Treatment planning. • Referral services. • Medication management. • Individual, family, therapeutic group and provider based case management services. • Crisis intervention. 	<p><u>PPO Network</u> You must call the Mental Health/ Substance Use Disorder Administrator to receive the Benefits</p>	<p>Hospital – Inpatient Stay \$250 Copayment plus 20% per Inpatient Stay. Physician’s Office Services 20% per visit.</p>	Yes	Yes
<p>Benefits include the following services provided on an inpatient basis:</p> <ul style="list-style-type: none"> • Partial hospitalization/day treatment. • Services at a Residential Treatment Facility. 	<p><u>PPO Non-Network</u> You must call the Mental Health/ Substance Use Disorder Administrator to receive the Benefits</p>	<p>Hospital – Inpatient Stay \$250 Copayment plus 40% per Inpatient Stay. Physician’s Office Services 40% per visit.</p>	Yes	Yes
<p>Benefits include Intensive outpatient treatment services provided on an outpatient basis.</p> <p>The MH/SUD Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.</p>	<p><u>Out-of-Area</u> You must call the Mental Health/ Substance Use Disorder Administrator to receive the Benefits</p>	<p>Hospital – Inpatient Stay \$250 Copayment plus 20% per Inpatient Stay. Physician’s Office Services 20% per visit.</p>	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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You are encouraged to contact the MH/SUD Administrator for referrals to providers and coordination of care.

Notification Required

Please remember that you must notify the MH/SUD Administrator to receive these Benefits. The MH/SUD Administrator phone number, 1-866-249-7606, also appears on your ID card.

If you don't notify the MH/SUD Administrator, Benefits will be reduced to 40% of Eligible Expenses.

Special Mental Health Programs and Services

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

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>16. Nutritional Counseling</p> <p>Covered Health Services provided by a registered dietician in an individual session for Covered Persons with medical conditions that require a special diet. Some examples of such medical conditions include:</p> <ul style="list-style-type: none"> • Diabetes mellitus. • Coronary artery disease. • Congestive heart failure. • Severe obstructive airway disease. • Gout. • Renal failure. • Phenylketonuria. • Hyperlipidemias. <p>Benefits are limited to three individual sessions during a Covered Person's lifetime for each medical condition.</p>	<p><u>PPO Network</u> No</p> <p><u>PPO Non-Network</u> No</p> <p><u>Out-of-Area</u> No</p>	<p>20%</p> <p>40%</p> <p>20%</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p>
<p>17. Obesity Surgery</p> <p>Surgical treatment of morbid obesity provided by or under the direction of a Physician. All of the following criteria must be met:</p> <ul style="list-style-type: none"> • Covered Person must have a minimum Body Mass Index (BMI) of 40 or a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or 	<p><u>PPO Network</u> No</p> <p><u>PPO Non-Network</u> No</p>	<p>20%</p> <p>40%</p>	<p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>exacerbated by obesity.</p> <ul style="list-style-type: none"> Covered Person must have documentation of a diagnosis of morbid obesity for a minimum of five (5) years from a Physician. Covered Person must be over the age of 21. 	<u>Out-of-Area</u> No	20%	Yes	Yes

18. Outpatient Surgery, Diagnostic and Therapeutic Services

Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:

- Surgery and related services.
- Lab and radiology/X-ray.
- Mammography testing.
- Other diagnostic tests and therapeutic treatments (including cancer chemotherapy or intravenous infusion therapy).

Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient surgery, diagnostic and therapeutic services are described under *Professional Fees for Surgical and Medical Services* below.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

<u>PPO Network</u> No	20%	Yes	Yes
<u>PPO Non-Network</u> No	40%	Yes	Yes
<u>Out-of-Area</u> No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
19. Physician's Office Services				
Covered Health Services received in a Physician's office including:				
<ul style="list-style-type: none"> • Treatment of a Sickness or Injury. • Voluntary family planning. • *Preventive medical care. • *Well-baby and well-child care. 	<u><i>PPO Network</i></u>			
	No	Non-Preventive Care 20%	Yes	Yes
<ul style="list-style-type: none"> • *Routinely well woman examinations, including pap smears, pelvic examinations and mammograms. 	<u><i>PPO Non-Network</i></u>			
	No	*Preventive Care 0%	N/A	No
<ul style="list-style-type: none"> • *Routine well woman examinations, including pap smears, pelvic examinations and mammograms. • *Routine well-man examinations, including PSA tests. • *Routine physical examinations, including vision and hearing screenings. • *Immunizations. • *Allergy injections. • Shingles vaccine (supplied and administered in the Physician's office only) 	<u><i>PPO Non-Network</i></u>			
	No	40%	Yes	Yes
	<u><i>Out-of-Area</i></u>			
	No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
20. Professional Fees for Surgical and Medical Services	<u>PPO Network</u>	20%	Yes	Yes
Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility.	<u>PPO Non-Network</u>	40%	Yes	Yes
	<u>Out-of-Area</u>	20%	Yes	Yes
	<u>PPO Network</u>	20%	Yes	Yes
Prosthetic devices that replace a limb or body part including:	<u>PPO Non-Network</u>	40%	Yes	Yes
<ul style="list-style-type: none"> Artificial limbs. Artificial eyes. Breast prosthesis. 	<u>Out-of-Area</u>	20%	Yes	Yes
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. We provide Benefits for a single purchase, including repairs, of a type of prosthetic device. Benefits are provided for the replacement of each type of prosthetic device every five calendar years. At the Claims Administrator's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical				

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>condition occurs sooner than the three year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.</p> <p>Benefits for the purchase and repairs of prosthetic devices are limited to \$10,000 per lifetime. Once this limit is reached, Benefits continue to be available for items required by the Women's Health and Cancer Rights Act of 1998.</p>				
<p>22. Reconstructive Procedures</p> <p>Reconstructive procedures - services are considered reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part. By improving or restoring physiologic function it is meant that the target organ or body part is made to work better. An example of a reconstructive procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.</p> <p>Cosmetic Procedures - services are considered Cosmetic Procedures when they improve appearance without making an organ or body part work better. The fact that a person may suffer psychological consequences from the impairment does not classify surgery and other procedures done to relieve such consequences as a reconstructive procedure. Reshaping a nose with a prominent "bump" would be a good example of a Cosmetic Procedure because appearance would be improved, but there would be no effect on</p>	<p><u><i>PPO Network</i></u> Yes</p> <p><u><i>PPO Non-Network</i></u> Yes</p> <p><u><i>Out-of-Area</i></u> Yes</p>	<p>Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.</p> <p>Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.</p> <p>Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.</p>		

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>function like breathing. This Plan does not provide Benefits for Cosmetic Procedures.</p> <p>Some services are considered cosmetic in some circumstances and reconstructive in others. This means that there may be situations in which the primary purpose of the service is to make a body part work better, whereas in other situations, the purpose would be to improve appearance and function (such as vision) is not affected.</p> <p>A good example is upper eyelid surgery. At times, this procedure will improve vision, while on other occasions improvement in appearance is the primary purpose of the procedure.</p> <p>Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Other services identified in 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 Covered Health Service. You can contact Personal Health Support at the toll free telephone number shown on your ID card, 1-866-249-7606, for more information about Benefits for mastectomy-related services.</p>				
<p>Notify Personal Health Support</p>				
<p>Please remember that you should notify Personal Health Support five business days before receiving services. When you provide notification, Personal Health Support can verify that the service is a reconstructive procedure rather than a Cosmetic Procedure.</p>				

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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Cosmetic Procedures are always excluded from coverage.

23. 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.

The Plan gives the Claims Administrator the right to exclude from coverage rehabilitation services that are not expected to result in significant physical improvement in your condition within two months of the start of treatment. In addition, the Claims Administrator has the right to deny Benefits if treatment ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.

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

PPO Network

No

20%

Yes

Yes

PPO Non-Network

No

40%

Yes

Yes

Out-of-Area

No

20%

Yes

Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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- Please note that the Plan excludes any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

Any combination of PPO Network and PPO Non-Network Benefits is limited as follows:

- 30 visits of physical therapy per calendar year.
- 30 visits of occupational therapy per calendar year.
- 30 visits of speech therapy per calendar year.
- 20 visits of pulmonary rehabilitation therapy per calendar year.
- 20 visits of cardiac rehabilitation therapy per calendar year.

Out-of Area Benefits are limited as follows:

- 30 visits of physical therapy per calendar year.
- 30 visits of occupational therapy per calendar year.
- 30 visits of speech therapy per calendar year.
- 20 visits of pulmonary rehabilitation therapy per calendar year.
- 20 visits of cardiac rehabilitation therapy per calendar year.

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>24. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</p> <p>Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:</p> <ul style="list-style-type: none"> • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). <p>Any combination of PPO Network and PPO Non-Network Benefits is limited to 60 days per calendar year.</p> <p>Out-of-Area Benefits are limited to 60 days per calendar year.</p> <p>Please note that, in general, the intent of skilled nursing is to provide Benefits for Covered Persons who are convalescing from an Injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation and facility services which are less than those of a general acute Hospital but greater than those available in the home setting.</p> <p>The Covered Person is expected to improve to a predictable level of recovery.</p> <p>Benefits are available when skilled nursing and/or rehabilitation services are needed on a daily basis. Accordingly, Benefits are NOT available when these services are required intermittently (such as physical therapy three times a week).</p>	<p><u>PPO Network</u> Yes</p>	<p>20%</p>	<p>Yes</p>	<p>Yes</p>
	<p><u>PPO Non-Network</u> Yes</p>	<p>40%</p>	<p>Yes</p>	<p>Yes</p>
	<p><u>Out-of-Area</u> Yes</p>	<p>20%</p>	<p>Yes</p>	<p>Yes</p>

Description of Covered Health Service

Must You Notify Personal Health Support?

Your Copayment Or Coinsurance Amount
 % Coinsurance is based on a percent of Eligible Expenses

Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?

Do You Need to Meet Annual Deductible?

Benefits are NOT available for custodial, domiciliary or maintenance care (including administration of enteral feeds) which, even if it is ordered by a Physician, is primarily for the purpose of meeting personal needs of the Covered Person or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

(Custodial, domiciliary or maintenance care may be provided by persons without special skill or training. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, eating and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs.)

Notify Personal Health Support

Please remember that you must notify Personal Health Support as follows:

- For elective admissions: five business days before admission.
- For non-elective admission: within one business day or the same day of admission.
- For Emergency admissions: within two business days or the same day of admission, or as soon as is reasonably possible.

If you don't notify Personal Health Support, Benefits will be reduced to 40% of Eligible Expenses.

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>25. Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy</p> <p>Benefits for Spinal Treatment include chiropractic and osteopathic manipulative therapy. Benefits for Spinal Treatment when provided by a Spinal Treatment provider in the provider's office.</p> <p>Benefits include diagnosis and related services and are limited to one visit and treatment per day.</p> <p>Please note that the Plan excludes any type of therapy, service or supply including, but not limited to spinal manipulations by a chiropractor or other doctor for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.</p> <p>Any combination of Network and PPO Non-Network Benefits for Spinal Treatment is limited to 20 visits per calendar year.</p> <p>Out-of-Area Benefits for Spinal Treatment is limited to 20 visits per calendar year.</p>	<p><u>PPO Network</u> No</p>	<p>20%</p>	<p>Yes</p>	<p>Yes</p>
	<p><u>PPO Non-Network</u> No</p>	<p>40%</p>	<p>Yes</p>	<p>Yes</p>
	<p><u>Out-of-Area</u> No</p>	<p>20%</p>	<p>Yes</p>	<p>Yes</p>

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>26. Substance Use Disorder Services</p> <p>Substance Use Disorder Services include those received on an inpatient basis in a Hospital or an Alternate Facility and those received on an outpatient basis in a provider's office or at an Alternate Facility.</p> <p>Benefits include the following services provided on either an inpatient or outpatient basis:</p> <ul style="list-style-type: none"> • Diagnostic evaluations and assessment. • Treatment planning. • Referral services. • Medication management. • Individual, family, therapeutic group and provider-based case management. • Crisis intervention. • Detoxification (sub-acute/non-medical). <p>Benefits include the following services provided on an inpatient basis:</p> <ul style="list-style-type: none"> • Partial Hospitalization/Day Treatment. • Services at a Residential Treatment Facility. 	<p><u>PPO Network</u></p> <p>You must call the Mental Health/ Substance Use Disorder Administrator to receive the Benefits</p>	<p>Hospital – Inpatient Stay \$250 Copayment plus 20% per Inpatient Stay.</p> <p>Physician's Office Services 20% per visit.</p>	Yes	Yes
	<p><u>PPO Non-Network</u></p> <p>You must call the Mental Health/ Substance Use Disorder Administrator to receive the Benefits</p>	<p>Hospital – Inpatient Stay \$250 Copayment plus 40% per Inpatient Stay.</p> <p>Physician's Office Services 40% per visit.</p>	Yes	Yes
	<p><u>Out-of-Area</u></p> <p>You must call the Mental Health/ Substance Use Disorder Administrator to receive the Benefits</p>	<p>Hospital – Inpatient Stay \$250 Copayment plus 20% per Inpatient Stay.</p> <p>Physician's Office Services 20% per visit.</p>	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Benefits include Intensive Outpatient Treatment services provided on an outpatient basis.				
The MH/SUD Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.				
You are encouraged to contact the MH/SUD Administrator for referrals to providers and coordination of care.				
<p>Special Substance Use Disorder Programs and Services</p> <p>Special programs and services that are contracted under the MH/SUD Administrator may become available to you as part of your Substance Use Disorder Services benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Substance Use Disorder which may not otherwise be covered under this Plan. You must be referred to such programs through the MH/SUD Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.</p>				

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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Notification Required

Please remember that you must notify the MH/SUD Administrator to receive these Benefits. The MH/SUD Administrator phone number, 1-866-249-7606, also appears on your ID card.

If you don't notify the MH/SUD Administrator, Benefits will be reduced to 40% of Eligible Expenses.

27. Transplantation Services

Covered Health Services for the following organ and tissue transplants when ordered by a Physician. Benefits are available to the donor and the recipient when the recipient is covered under this Plan. The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Benefits are available for the transplants listed below.

Personal Health Support notification is required for all transplant services.

The service described under Transportation and Lodging below are Covered Health Services **ONLY** in connection with a transplant received at a Designated United Resource Network Facility.

- 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. If a separate charge is made for bone marrow/stem cell search, a Maximum Benefit of

PPO Network

Yes

20%

Yes

Yes

PPO Non-Network

Yes

40%

Yes

Yes

Out-of-Area

Yes

20%

Yes

Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>\$25,000 is payable for all charges made in connection with the search.</p> <ul style="list-style-type: none"> • Heart transplants. • Heart/lung transplants. • Lung transplants. • Kidney transplants. • Kidney/pancreas transplants. • Liver transplants. • Liver/small bowel transplants. • Pancreas transplants. • Small bowel transplants. 				
<p>Benefits for cornea transplants that are provided by a Physician at a Network Hospital are paid as if the transplant was received at a Designated United Resource Network Facility. We do not require that cornea transplants be performed at a Designated United Resource Network Facility in order for you to receive the highest level of Network Benefits.</p>				
<p>Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage, unless determined by Care Coordination to be a proven procedure for the involved diagnoses.</p>				
<p>Under the Plan there are specific guidelines regarding Benefits for transplant services. Contact Personal Health Support at the toll free</p>				

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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telephone number, 1-866-249-7606, shown on your ID card for information about these guidelines.

Transportation and Lodging

Personal Health Support will assist the patient and family with travel and lodging arrangements only when services are received from a Designated United Resource Network Facility. Expenses for travel, and lodging 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.
- Eligible Expenses for lodging 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 United Resource Network Facility.
- If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging 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, and lodging expenses incurred by the transplant recipient and companion(s) and

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Or Coinsurance Amount % Coinsurance is based on a percent of Eligible Expenses	Does Copayment/Coinsurance Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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reimbursed under this Plan in connection with all transplant procedures.

Notify Personal Health Support

You must notify Personal Health Support as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). **If you don't notify Personal Health Support, Benefits will be reduced to 40% of Eligible Expenses.**

28. Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this section.

PPO Network

No

20%

Yes

Yes

PPO Non-Network

No

40%

Yes

Yes

Out-of-Area

No

20%

Yes

Yes

Section 2: What's Not Covered-- Exclusions

This section contains information about:

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

How We Use Headings in this Section

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

Plan Exclusions

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

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

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

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

A. Alternative Treatments

1. Acupressure.
2. Aromatherapy.
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.
7. Services received by a naturopath.
8. Holistic or homeopathic care.

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.

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

6. Devices and computers to assist in communication and speech.
7. Home remodeling to accommodate a health need (such as, but not limited to, ramps and swimming pools).

C. Dental

1. Dental care except as described in Section 1: What's Covered--Benefits under the heading *Dental Services - Accident Only*.
2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
 - Extraction, restoration and replacement of teeth.
 - Medical or surgical treatments of dental conditions.
 - Services to improve dental clinical outcomes.
3. Dental implants.
4. Dental braces.
5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in (Section 1: What's Covered--Benefits) under the heading *Dental Services - Accident Only*.

6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly.

D. Drugs

Note: Prescription Drugs are provided under a separate program administered by Express Scripts. See the "Prescription Drugs" section of this booklet.

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

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 or Investigational Services and Unproven Services are excluded. The fact that an Experimental or Investigational Service or an 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 or Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

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

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

4. Treatment of subluxation of the foot.
5. Shoe orthotics.

G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
 - Elastic stockings.
 - Ace bandages.
 - Gauze and dressings.
 - Syringes.
 - Diabetic test strips.
3. Orthotic appliances and devices that straighten or re-shape a body part, except as described in (Section 1: What's Covered--Benefits) under the heading *Durable Medical Equipment* when all of the following are met:
Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any braces available over the counter.
 - prescribed by a Physician for a medical purpose; and
 - custom manufactured or custom fitted to an individual Covered Person.
4. Cranial banding.
5. Tubings, nasal cannulas, connectors and masks are not covered except when used with Durable Medical Equipment (as described in Section 1: What's Covered--Benefits).

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

H. Mental Health/Substance Use Disorder

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

1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
2. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that, in the reasonable judgment of the MH/SUD Administrator, are any of the following:
 - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
 - Not consistent with the MH/SUD Administrator's level of care guidelines or best practices as modified from time to time.
 - Not clinically appropriate for the patient's Mental Illness, Substance Use Disorder or condition based on generally accepted standards of medical practice and benchmarks.
3. Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
4. Mental Health Services as treatment for a primary diagnosis of insomnia other sleep disorders, sexual dysfunction disorders,

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

feeding disorders, neurological disorders and other disorders with a known physical basis.

4. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias (sexual behavior that is considered deviant or abnormal).
5. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
6. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.
7. Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
8. Mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
9. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction.
10. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders.

I. Nutrition

1. Megavitamin and nutrition based therapy.
2. Except as described in Section 1: What's Covered -- Benefits under *Nutritional Counseling*, nutritional counseling for either individuals or groups, including weight loss programs, health clubs and spa programs.
3. Enteral feedings and other nutritional and electrolyte formulas, supplements, including infant formula and, donor breast milk,

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

nutritional supplements, dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins, and oral minerals except when unless they are the only sole source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded; except when a certain nutritional formula treats a specific inborn error of metabolism.

- foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
- oral vitamins and minerals;
- meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
- other dietary and electrolyte supplements.

J. Physical Appearance

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

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

3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
5. Wigs regardless of the reason for the hair loss.
6. Services received from a personal trainer.
7. Liposuction.

K. Providers

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

This exclusion does not apply to mammography testing.

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L. Reproduction

1. Health services and associated expenses for infertility treatments.
2. Surrogate parenting.
3. The reversal of voluntary sterilization.
4. Fees or direct payment to a donor for sperm or ovum donations.
5. Monthly fees for maintenance and/or storage of frozen embryos.

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 when UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.

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

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 multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Health Services* in Section 1: What's Covered--Benefits, unless determined by Care Coordination to be a proven procedure for the involved diagnoses.

O. Travel

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

P. Vision (see separate Vision Benefit)

1. Purchase cost of eye glasses or contact lenses.
2. Fitting charge for eye glasses or contact lenses.
3. Eye exercise or vision therapy.
4. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as radial keratotomy, laser, and other refractive eye surgery.

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

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. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
4. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
6. In the event that a Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments and/or Annual Deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.

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8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered to be medical or dental in nature, including oral appliances.
9. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly.
10. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury dislocation, tumor or cancer. Orthognathic surgery (procedure to correct underbite or overbite), jaw alignment and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.
11. Non-surgical treatment of obesity, including morbid obesity.
12. Surgical treatment of obesity excluding severe morbid obesity (with a BMI greater than 40).
13. Growth hormone therapy.
14. Gender reassignment (sex transformation) surgery.
15. Custodial Care or maintenance care.
16. Domiciliary care.
17. Private Duty Nursing.
18. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of service provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under *Hospice Care* in Section 1: What's Covered--Benefits.
19. Rest cures.
20. Psychosurgery.
21. Treatment of benign gynecomastia (abnormal breast enlargement in males).
22. Medical and surgical treatment of excessive sweating (hyperhidrosis).
23. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
24. Appliances for snoring.
25. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
26. 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.
27. Any charge for services, supplies or equipment advertised by the provider as free.
28. Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency.
29. Any charges prohibited by federal anti-kickback or self-referral statutes.
30. Chelation therapy, except to treat heavy metal poisoning.
31. Any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services.
32. Outpatient rehabilitation services, spinal treatment, manipulative treatment or supplies including, but not limited to spinal manipulations by a chiropractor or other doctor, for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.
33. Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness, such as asthma or allergies.
34. Speech therapy to treat stuttering, stammering, or other articulation disorders.

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35. Breast reduction surgery that is determined to be a Cosmetic Procedure.

This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under *Reconstructive Procedures* in (Section 1: What's Covered--Benefits).

36. Foreign language and sign language services.

37. Panniculectomy, abdominoplasty, thighplasty, brachioplasty and mastopexy. This exclusion does not apply to *Reconstruction - Post-Mastectomy* in Section 1: What's Covered--Benefits.

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Section 3: Obtaining Benefits

This section includes information about:

- Benefits for Covered Health Services.
- Your responsibility for notification.
- Emergency Health Services.

Benefits for Covered Health Services

For the PPO Plan, Network Benefits are generally paid at a higher level than Non-Network Benefits. Network Benefits are payable for Covered Health Services which are any of the following:

- Provided by a Network Physician or other Network provider.
- Emergency Health Services.
- Covered Health Services that are described as Network Benefits in Section 1: What's Covered--Benefits.

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The following compares Network and Non-Network Benefits.

Comparison of Network and Non-Network Benefits

	Network	Non-Network
Benefits	A higher level of Benefits means less cost to you. See Section 1: What's Covered--Benefits.	A lower level of Benefits means more cost to you. See Section 1: What's Covered--Benefits.
Who Should Notify Personal Health Support	Notify <i>Personal Health Support</i> for certain Covered Health Services. Failure to notify will result in reduced Benefits or no Benefits. See <i>Must You Notify Personal Health Support?</i> column in Section 1.	
Who Should File Claims	Not required. The Claims Administrator pays Network providers directly.	You must file claims. See Section 5: How to File a Claim.
Outpatient Emergency Health Services	Emergency Health Services are always paid as a Network Benefit and are paid the same whether you are in- or out of the Network. That means that if you seek Emergency care at a non-Network facility, you are not required to meet the Annual Deductible or pay any difference between Eligible Expenses and the amount billed by the provider.	

If you are in the Out-of-Area Plan:

Benefits are payable for Covered Health Services that are provided by or under the direction of a Physician or other provider and are generally paid at the in-network benefit level even if the provider is not in the network.

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Whenever possible, however, you are encouraged to use in-network providers. The cost of such services will be lower than for out-of-network providers. Therefore, your co-payment, which is a percentage of covered (eligible) charges, will be lower as well.

Provider Network

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

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

You may request a directory of Network providers at no cost to you. Provider directories are always available on myuhc.com. However, before obtaining services you should always verify the Network status of a provider. A provider's status may change. You are responsible for verifying a provider's Network status prior to receiving services, even when you are referred by another Network provider. You can verify the provider's status or request a provider directory by calling the Claims Administrator.

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

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers agree to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider

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for only some products. Refer to your provider directory or contact the Claims Administrator for assistance.

Designated United Resource Network Facilities and Other Providers

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

PPO Non-Network Benefits

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

UnitedHealth PremiumSM Program

The UnitedHealth Premium program evaluates Network Physicians in certain specialties and facilities for specific services currently in UnitedHealthcare's Network. Physicians and facilities are evaluated first against quality criteria and then against efficiency of care criteria if quality criteria are met. You may obtain additional information regarding the UnitedHealth Premium program online at www.myuhc.com or by calling the number on the back of your ID card.

Your Responsibility for Notification

You must notify Personal Health Support before getting certain Covered Health Services from Network, non-Network and Out-of-

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Area providers. The details are shown in the *Must You Notify Personal Health Support?* column in Section 1: What's Covered--Benefits. If you fail to notify Personal Health Support, 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.

Personal Health Support

When you notify Personal Health Support as described above, they will work with you to implement the Personal Health Support 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 are living with a chronic condition or dealing with complex health care needs, a primary nurse, referred to as a UnitedHealth MyNurseSM, may be assigned to you to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The UnitedHealth MyNurseSM will provide you with their telephone number so you can call them with questions about your condition, or your overall health and well-being.

HealtheNotesSM

The Claims Administrator provides a service called HealtheNotes to help educate members and make suggestions regarding your medical care. HealtheNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes report may include health tips and other wellness information.

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The Claims Administrator makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine.

If your Physician identifies any concerns after reviewing his or her HealtheNotes report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

PPO Plan and Out-of-Area 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.

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

- If you are confined in a non-Network Hospital after you receive Emergency Health Services, Personal Health Support must be notified within two business days or on the same day of admission if reasonably possible. Personal Health Support may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date Personal Health Support decides a transfer is medically appropriate, PPO Non-Network

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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 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 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 complete an enrollment form. As an Eligible Person, you may also enroll your Eligible Spouse and Eligible Dependent Children. If you do not enroll your Eligible Spouse or Eligible Dependent Children when you enroll, you may not later enroll them. The Plan Administrator or the Employer from which you retired 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.

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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 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. PPO Network Benefits are available only if you receive Covered Health Services from Network Providers.

If You Are Eligible for Medicare

If you or your dependent are eligible for Medicare A and B, either because of age (i.e., over age 65) or because of disability if under age 65, your benefits under this Plan will be reduced.

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

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Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Eligible Person	<p>Eligible Person usually refers to a former employee of a Sponsoring Employer (or predecessor employer) who meets the eligibility rules established by the Plan Administrator. When an Eligible Person actually enrolls, we refer to that person as a Retiree. For a complete definition of Eligible Person and Retiree, see Section 10: Glossary of Defined Terms. If both spouses are Eligible Persons, each may enroll as a Retiree, or be covered as an Enrolled Dependent of the other, but not both.</p> <p>Except as we have described in Section 4: When Coverage Begins, Eligible Persons may not enroll.</p>	<p>The Plan Administrator determines who is eligible to enroll under the Plan.</p>
Dependent	<p>Dependent generally refers to the Eligible Person's Eligible Spouse and Eligible Dependents. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent, Eligible Dependents, Spouse, Eligible Spouse and Enrolled Dependent, see Section 10: Glossary of Defined Terms.</p> <p>Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan, unless the Eligible Person is deceased and there is a Surviving Spouse.</p>	<p>The Plan Administrator determines who qualifies as a Dependent.</p>
Surviving Spouse	<p>Surviving Spouse refers to the Surviving Spouse of an Eligible Person. The Surviving Spouse of an Eligible Person may enroll at the Eligible Person's death if he or she is covered at the Eligible Person's death under a HEWT-sponsored group health plan.</p>	<p>The Plan Administrator determines who qualifies as a Surviving Spouse.</p>

When to Enroll and When Coverage Begins

When to Enroll	Who Can Enroll	Begin Date
Initial Enrollment Period <p data-bbox="155 404 623 493">The Initial Enrollment Period is the first period of time when Eligible Persons can enroll.</p>	Eligible Persons may enroll themselves and their Eligible Dependents only upon first becoming eligible for this Plan. If an Eligible Person does not enroll when first eligible or enroll his or her Dependents, the Eligible Person or Dependents that are not enrolled may not enroll later. An Eligible Person who enrolls and who thereafter has a new Dependent (by reason of marriage, birth, etc.) may not enroll those new Dependents.	Coverage begins on the date identified by the Plan Administrator, if the Plan Administrator receives the completed enrollment form and any required contribution for coverage within 31 days of the date the Eligible Person becomes eligible to enroll.

Section 5: How to File a Claim

This section provides you with information about:

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

Network Benefits

In general, if you receive Covered Health Services from a Network provider, the Claims Administrator will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Copayment, please contact the provider or call the Claims Administrator at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Copayment owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a Non-Network provider, you (or the provider if they prefer) must send the bill to the Claims Administrator for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to the Claims Administrator at the address on the back of your ID card.

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If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting myuhc.com, calling the toll-free number on your ID card or contacting Us. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address.
- The patient's name, age and relationship to the Employee.
- The number as shown on your ID card.
- The name, address and tax identification number of the provider of the service(s).
- A diagnosis from the Physician.
- The date of service.
- An itemized bill from the provider that includes:
 - The Current Procedural Terminology (CPT) codes.
 - A description of, and the charge for, each service.
 - The date the Sickness or Injury began.
 - 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 and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

The above information should be filed with us at the address on your ID card.

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After the Claims Administrator has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the Non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

The Claims Administrator will pay Benefits to you unless:

- The provider notifies the Claims Administrator that you have provided signed authorization to assign Benefits directly to that provider.
- You make a written request for the Non-Network provider to be paid directly at the time you submit your claim.

The Claims Administrator will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider has assigned Benefits to that third party.

Health Statements

Each month in which the Claims Administrator processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at www.myuhc.com. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that the Claims Administrator send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim

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you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at myuhc.com. See (Section 10: Glossary of Defined Terms) for the definition of Explanation of Benefits.

NOTE: Timely Filing of Claims - All claim forms must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by Us. This 12-month requirement 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.

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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.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call the Claims Administrator at the number on your ID card before requesting a formal appeal. If the Claims Administrator cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include:

- The patient's name and ID number as shown on the ID card.
- The provider's name.
- The date of medical service.
- The reason you disagree with the denial.
- Any documentation or other written information to support your request.

You or your enrolled Dependent may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, Utah 84130-0432

For Urgent Care requests for Benefits that have been denied, you or your provider can call the Claims Administrator at the toll-free number on your ID card to request an appeal.

Note: Types of claims - The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent care request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim.

Review of an Appeal

The Claims Administrator will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- An appropriate individual(s) who did not make the initial benefit determination.

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- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Prior to issuing a determination on your appeal:

- You have the right to review your claim file and have access to and request copies of documents, records and other information that is relevant to your claim.
- You have the right to present evidence and testimony, including written comments, records and other information, relating to your claim.
- If any new or additional evidence is considered, relied upon or generated by the Claims Administrator in connection with your claim during the appeal, the Claims Administrator will provide you with such information, free of charge, prior to the issuance of its determination, and you will have reasonable opportunity to respond.
- If the Claims Administrator will uphold the denial based on a new or additional rationale, the Claims Administrator will provide you with such rationale, free of charge, prior to the issuance of its determination, and you will have reasonable opportunity to respond.

Once the review is complete, if the Claims Administrator upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

The Claims Administrator must notify you of the appeal determination within 15 days after receiving the completed appeal for a pre-service denial and 30 days after receiving the completed post-service appeal.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or

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appeals and submit opinions and comments. The Claims Administrator will review all claims in accordance with the rules established by the U.S. Department of Labor. The Claims Administrator's decision will be final, unless you choose to make a voluntary appeal to the Plan Administrator or to request an external review.

Voluntary Appeal

If you are not satisfied with the first level appeal decision, you have the right, but are not required, to request a voluntary appeal to the Plan Administrator. You may also request an external review if your claim is based in whole or in part on a medical judgment or involves a rescission of coverage. Note that if your claim is eligible for an external review, you may, but are not required, to request a voluntary appeal before you submit your request for an external review. If you do not request a voluntary appeal, your external review request must be submitted within 4 months from the receipt of the first level appeal decision.

If you decide to request a voluntary appeal, your voluntary appeal request must be submitted to the Plan Administrator within 60 days from the receipt of the first level appeal decision, or, if later, within 180 days following the initial adverse benefit determination.

If you request a voluntary appeal to the Plan Administrator, you will be provided the following:

- The opportunity to submit written comments, documents, records and other information that were submitted to the Claims Administrator in connection with your first level appeal.
- To receive upon request and free of charge reasonable access to, and copies of, all documents, records and other information relevant to your appeal that are sufficient to enable you to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal.

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- A review that takes into account all comments, documents, records and all other information relating to the claim submitted by you at the time of your first appeal to the Claims Administrator.
- A review conducted by the Plan Administrator that does not afford deference to the initial adverse benefit determination.
- The Plan Administrator will identify all medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination without regard to whether the advice was relied upon.
- Any health care professional engaged for purposes of a consultation with respect to your appeal will be an individual who is neither an individual who was consulted in connection with the initial adverse benefit determination nor a subordinate of such individual.

The voluntary appeal process is subject to the following terms and conditions:

- HEWT waives any right to assert that you have failed to exhaust administrative remedies because you did not elect to submit a benefit dispute to a voluntary appeal.
- The HEWT agrees that any statute of limitations or other defense based on timeliness is tolled during the time that your voluntary appeal is pending, but only if you comply with the requirements for a voluntary appeal. If you elect not to submit a voluntary appeal or do not comply with the requirements for submitting a voluntary appeal, the statute of limitations starts to run when the decision for your first level appeal to the Claims Administrator is issued.
- You may elect to submit a benefit dispute to a voluntary appeal only after you have exhausted the appeals process to the Claims Administrator that is responsible for paying the claims;

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- Upon request, the Plan Administrator will provide you with information relating to the voluntary level of appeal that is sufficient to enable you to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the your decision of whether to submit a benefit dispute to the voluntary level of appeal will have no effect on your rights to any other benefits under the plan and information about the applicable rules, your right to representation, the process for selecting the decision-maker, and the circumstances, if any, that may affect the impartiality of the decision-maker (e.g., any financial or personal interests in the result or any past or present relationship with any party to the review process).
- HEWT will not impose any fees or costs on you as part of the voluntary level of appeal.

You will receive notification of the Plan Administrator's decision on your appeal not later than 30 days after receipt by the Plan Administrator of your request for review unless the Plan Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time, in which you will be notified prior to the termination of the initial review period. Notice shall be provided to you in writing or electronically.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care request for Benefits- a request for Benefits provided in connection with Urgent Care services, as defined in (Section 10: Glossary of Defined Terms).
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided.

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- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you, the Claims Administrator and the Plan Administrator are required to follow.

Urgent Care Request for Benefits*

Type of Request for Benefits or Appeal	Timing
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	24 hours
You must then provide completed request for Benefits information to the Claims Administrator within:	48 hours after receiving notice of additional information required
The Claims Administrator must notify you of the benefit determination within:	72 hours
If the Claims Administrator denies your request for Benefits, you must appeal the adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the appeal decision within:	72 hours after receiving the appeal
*You do not need to submit Urgent Care appeals in writing. You should call the Claims Administrator as soon as possible to appeal an Urgent Care request for Benefits.	

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Pre-Service Request for Benefits

Type of Request for Benefits or Appeal	Timing
If your request for Benefits is filed improperly, the Claims Administrator must notify you within:	5 days
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	15 days
You must then provide completed request for Benefits information to the Claims Administrator within:	45 days
If the Claims Administrator denies your initial request for Benefits, they must notify you of the denial:	
<ul style="list-style-type: none"> If the initial request for Benefits is complete, within: 	15 days
<ul style="list-style-type: none"> After receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within: 	15 days
You must appeal the request for Benefits denial no later than:	180 days after receiving the denial
The Claims Administrator must notify you of the first level appeal decision within:	15 days after receiving the first level appeal

Type of Request for Benefits or Appeal	Timing
If you choose to file a voluntary appeal, you must appeal the first level appeal (file a voluntary appeal) within:	60 days after receiving the second level appeal decision
The Plan Administrator must notify you of the voluntary appeal decision within:	30 days after receiving the voluntary appeal

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Post-Service Claims

Type of Request for Benefits or Appeal	Timing
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	30 days
You must then provide completed claim information to the Claims Administrator within:	45 days after receiving an extension notice
If the Claims Administrator denies your initial request for Benefits, they must notify you of the denial:	
<ul style="list-style-type: none"> If the initial claim is complete, within: 	30 days
<ul style="list-style-type: none"> After receiving the completed claim (if the initial request for Benefits is incomplete), within: 	30 days
You must appeal the claim denial no later than:	180 days after receiving the denial
The Claims Administrator must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
If you choose to file a voluntary appeal, you must appeal the second level appeal (file a voluntary appeal) within:	60 days after receiving the second level appeal decision
The Plan Administrator must notify you of the voluntary appeal decision within:	30 days after receiving the voluntary appeal

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Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, 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 request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against Us or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. 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 section. After completing that process, if you want to bring a legal action against

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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 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.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- Another employer sponsored health benefits plan.
- A medical component of a group long-term care plan, such as skilled nursing care.
- No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
- Medical payment benefits under any premises liability or other types of liability coverage.
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any

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remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.
- A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent.
- If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.
- Your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
 - the parents are married or living together whether or not they have ever been married and not legally separated.
 - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one

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parent is responsible for health care, the child will be covered under the plan of:

- the parent with custody of the child; then
- the Spouse of the parent with custody of the child; then
- the parent not having custody of the child; then
- the Spouse of the parent not having custody of the child;
- Plans for active employees pay before plans covering laid-off or retired employees;
- The plan that has covered the individual claimant the longest will pay first. The expenses must be covered in part under at least one of the plans.
- Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- The Plan determines the amount it would have paid had it been the only plan involved.
- The Plan pays the entire difference between the allowable expense and the amount paid by the primary plan – as long as this amount is not more than the Plan would have paid had it been the only plan involved.
- At the end of the calendar year, the benefit reserve returns to zero. A new benefit reserve is created for each calendar year.

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The maximum combined payment you may receive from all plans cannot exceed 100% of the total allowable expense. See the textbox below for the definition of allowable expense.

What is an allowable expense?

For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

Determining the Allowable Expense When This Plan is Secondary

When this Plan is secondary, the allowable expense is the primary plan's Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their Spouses age 65 or older.
- Individuals with end-stage renal disease, for a limited period of time.

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Determining the Allowable Expense When This Plan is Secondary

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

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

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

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan Administrator should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, the Plan Administrator reserves the right to recover the excess amount, by legal action if necessary.

Refund of Overpayments

If the employer pays for 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 the employer if:

- all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- all or some of the payment the employer made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

The refund equals the amount the Employer paid in excess of the amount that should have been paid under the Plan. If the refund is

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

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the employer may reduce the amount of any future Benefits for the Covered Person that are payable under the Plan. The reductions will equal the amount of the required refund. The employer may have other rights in addition to the right to reduce future Benefits.

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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.
- Continuation of coverage under federal law (COBRA).

General Information about When Coverage Ends

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

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

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

An Enrolled Dependent's coverage ends on the date the Employee's coverage ends or sooner if the Employee chooses to end the Dependent's coverage or as otherwise set forth in this SPD.

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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	<p>Your coverage ends on the date you are no longer eligible to be a Retiree or Enrolled Dependent. You are no longer eligible to be a Retiree under this Plan when you reach age 65. You, your Spouse and certain Eligible Dependents may be eligible for the medical plan for Medicare-eligible retirees.</p> <p>Your Enrolled Dependents will cease to be eligible when you are no longer eligible unless your eligibility ends by reason of your death. Please refer to Section 10: Glossary of Defined Terms for a more complete definition of the terms “Eligible Dependent Children,” “Eligible Person,” “Eligible Spouse,” “Retiree,” “Dependent,” and “Enrolled Dependent.”</p> <p><u>Death.</u> If you (the Retiree) die, coverage for your Enrolled Dependents may be continued as follows: coverage for a dependent child (children) may continue until the date the deceased Retiree would have reached age 65 or the children no longer qualify as Dependents. Coverage for the spouse may continue until the spouse reaches age 65 or until such time as the spouse remarries or fails to make the required contributions, if sooner. Remarriage of a spouse does not render other Dependents ineligible. Your Eligible Spouse and certain Eligible Dependent Children may be eligible for the medical plan for Medicare-eligible retirees. This period of coverage will be credited toward satisfying the maximum coverage provided under COBRA discussed below.</p>
The Claims Administrator Receives Notice to End Coverage	Your coverage ends on the date the Claims Administrator receives written notice from us (i.e., the HEWT or your employer), instructing the Claims Administrator to end your coverage, or the date requested in the notice, if later.
Failure to Pay	You failed to pay a required contribution.

Other Events Ending Your Coverage

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

Ending Event	What Happens
Fraud, Misrepresentation or False Information	The Employee commits an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include, but are not limited to, false information relating to another person's eligibility or status as a Dependent.
Threatening Behavior	You 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 all of the following are true regarding the Enrolled Dependent child:

- Before reaching age 23.
- Is not able to be self-supporting because of mental retardation or physical handicap.
- Depends mainly on the Employee for support.

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

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

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

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

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

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.

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 how COBRA may apply to you as a Retiree or Enrolled Dependent, and regarding your right to continue coverage.

If you are the spouse of a Retiree covered by the Health Plan, you have the right to elect COBRA continuation coverage for yourself if you lose your group health coverage under the Health Plan for any of the following qualifying events:

- The death of your spouse;
- Divorce or legal separation from your spouse; or
- Your spouse becomes entitled to Medicare benefits under Title XVIII of the Social Security Act.

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A dependent child of a Retiree covered by the Health Plan has the right to elect COBRA continuation coverage if the dependent child's group health coverage under the Health Plan is lost for any of the following qualifying events:

- The death of the employee-parent;
- The parents' divorce or legal separation;
- The employee-parent becomes entitled to Medicare benefits under Title XVIII of the Social Security Act; or
- The dependent ceases to be a "dependent child" under the Health Plan.

Electing COBRA Continuation Coverage

Under the law, the covered Retiree or a covered family member has the responsibility to inform the Plan Administrator of the Retiree's divorce or legal separation, or a child losing dependent status under the Health Plan. This notice must be given to the Plan Administrator within sixty (60) days after the later of (1) the date of such an event, or (2) the date on which the affected Retiree or family member would otherwise lose coverage because of such event. If this notice is not given to the Plan Administrator within the required 60-day period, the affected Retiree or family member will not be entitled to elect COBRA continuation coverage.

The Employer has the responsibility to notify the Plan Administrator of the Retiree's death, or the Retiree becoming entitled to Medicare under Title XVIII of the Social Security Act.

When the Plan Administrator is notified that one of these qualifying events has occurred, the Plan Administrator will in turn notify the appropriate individuals (also called "qualified beneficiaries") that they have the right to elect COBRA continuation coverage. COBRA continuation coverage must be elected by such individuals within

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sixty (60) days after the later of (1) the date that coverage under the Health Plan would otherwise terminate due to the qualifying event, or (2) the date that these individuals are provided with written notification of their right to elect COBRA continuation coverage. If COBRA continuation coverage is not elected within this 60-day period, the Health Plan coverage will end retroactive to the date that coverage would have otherwise ended due to the COBRA qualifying event, and the affected family member will not be entitled to elect COBRA continuation coverage. While an election by a covered spouse will be treated as an election of COBRA continuation coverage by the entire family, each family member may make a separate election as to COBRA continuation coverage. This means that a covered spouse or dependent child may separately elect COBRA continuation coverage. A covered spouse or dependent may elect COBRA continuation coverage even if covered under another group health plan or Medicare prior to electing COBRA continuation coverage.

Extent of Coverage

If continuation of coverage is elected, the Health Plan is required to provide COBRA continuation coverage which, at the time that coverage is being provided, is identical to the coverage provided under the Health Plan to similarly situated Health Plan participants who have not experienced a qualifying event (called "non-COBRA beneficiaries"). For example, if a Retiree dies leaving a spouse and two dependent children covered under the Health Plan, they would be entitled to the same benefits as the covered spouse and dependent children of a Retiree. If the benefits for similarly situated non-COBRA beneficiaries are modified, the changes will apply to those who have COBRA continuation coverage as well.

COBRA continuation coverage may be maintained for up to 36 months.

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In general, your covered dependents (if any) will only be given an opportunity to continue the coverage they were receiving immediately before the qualifying event. In a few circumstances, however, they may elect alternative coverage that the Plan makes available to Retirees, such as:

- (1) If you participate in a region-specific HMO that will not service your health needs in the area to which you are relocating, you must be given an opportunity to elect alternative coverage that the employer makes available to active employees.
- (2) You and your covered dependents (if any) will have the same opportunity as a Retiree to change your coverage at open enrollment.

When COBRA Continuation Coverage Ends

The law provides that COBRA continuation coverage will be cut short for any of the following reasons:

- (1) Your former Employer no longer provides group health coverage to any of its employees;
- (2) The premium for the COBRA continuation coverage is not paid on a timely basis (the first premium payment is payable in a lump sum forty five (45) days after electing COBRA continuation coverage; all subsequent premium payments are payable within thirty (30) days after the due date);
- (3) The covered individual first becomes, after the date of the COBRA continuation coverage election, covered under another group health plan (as an employee or otherwise) that does not contain any exclusion or limitation with respect to any preexisting condition of that individual (other than an exclusion or limitation that does not apply to, or is satisfied by, such

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individual by reason of the Health Insurance Portability and Accountability Act of 1996);

- (4) The covered individual first becomes, after the date of the COBRA continuation coverage election, entitled to Medicare (under Title XVIII of the Social Security Act); or
- (5) Upon the occurrence of any event (such as submission of fraudulent claims) by a covered individual that permits termination of Health Plan coverage for cause with respect to similarly situated non-COBRA beneficiaries.

We ask that covered individuals notify the Plan Administrator if an event occurs that is listed in number (3) or (4) above within thirty (30) days after becoming eligible for such other group health plan coverage or entitled to Medicare.

Cost of Coverage

The cost of COBRA continuation coverage will generally not exceed 102% of the cost for coverage under the Health Plan. The cost of COBRA continuation coverage will increase in the middle of the 12-month determination period only in the following instances:

- (1) where the qualified beneficiary changes to more expensive coverage, or
- (2) where the Health Plan was previously requiring payment of less than the maximum permissible amount.

An individual seeking COBRA continuation coverage is liable for the cost of that coverage during the entire applicable 36-month period (measured from the date that coverage would otherwise end due to the qualifying event). Due to the required sixty (60) day COBRA election period, it is likely that a covered individual will be responsible for retroactive premiums. These premiums must be paid in a lump sum within forty five (45) days after electing COBRA continuation coverage in order for the COBRA continuation

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coverage to be effective. After that payment, premiums are due on a monthly basis. Coverage will terminate if premiums are not paid within thirty (30) days after the date they are due.

An individual need not show proof of insurability to elect COBRA continuation coverage.

Coverage Expires

When COBRA continuation coverage expires after 36 months, an individual has the opportunity to enroll in an individual conversion health plan provided by the Health Plan if such option is otherwise generally available to similarly situated non-COBRA beneficiaries under the group health plan.

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

Relationship with Providers

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

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

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

The Plan Administrator is solely responsible for all of the following:

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

Your Relationship with Providers

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

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

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

Incentives to Providers

The Claims Administrator pays Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost

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efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

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

The methods used to pay specific Network providers may vary. From time to time, the payment method may change. If you have questions about whether your Network provider's contract includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact the Claims Administrator at the telephone number, 1-866-249-7606, shown on your ID card. They can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes the Claims Administrator may offer 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.

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Interpretation of Benefits

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

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

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

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our sole discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

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

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Amendments to the Plan

Although we expect to continue the Plan indefinitely, we reserve the right, to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at our sole discretion.

Our decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or Employee Retirement Income Security Act of 1974 (ERISA), or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If we do change or terminate a plan, we may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and our decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to us and others as may be required by any applicable law.

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. The terms of this Plan may not be amended by oral statements made by the Plan Sponsor, the Plan Administrative Committee, the Claims Administrator, or any other person. In the

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event an oral statement conflicts with any term of the Plan, the Plan terms will control. It is your responsibility to confirm the accuracy of statements made by us or our designees, including the Claims Administrator, in accordance with the terms of this SPD and other Plan documents.

Information and Records

We and the Claims Administrator may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We and the Claims Administrator may request additional information from you to decide your claim for Benefits. We and the Claims Administrator will keep this information confidential. We and the Claims Administrator may also use your de-identified data for commercial purposes, including research, as permitted by law.

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 and 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 Retiree'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 law or regulation. During and after the term of the Plan, we, the Claims Administrator, and our related entities may use and transfer

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the information gathered under the Plan in a de-identified format for commercial purposes, including 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 the Claims Administrator, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, we and 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. Our designees have the same rights to this information as the Plan Administrator.

Examination of Covered Persons

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

Workers' Compensation not Affected

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

Medicare Eligibility

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

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

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

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

Subrogation and Reimbursement

The Plan has a right to subrogation and reimbursement.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which a third party is alleged to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is alleged to be responsible.

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Subrogation - Example

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

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

Reimbursement - Example

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages;
- the Plan Sponsor (for example workers' compensation cases);
- any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto,

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homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators; and

- any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
 - notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
 - providing any relevant information requested by the Plan;
 - signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim;
 - responding to requests for information about any accident or injuries;
 - making court appearances;
 - obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses; and
 - complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and

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costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to Hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you 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, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine,"

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claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the Benefits the Plan has paid for the Sickness or Injury.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in your name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its

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interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover benefits it has paid on you or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the calendar year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

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If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Claims Administrator should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under the Coordination of Benefits provision, you should pay the excess back promptly. Otherwise, we may recover the amount in the form of salary, wages, or benefits payable under any company-sponsored benefit plans, including this Plan. We also reserve the right to recover any

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overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, the Claims Administrator reserves the right to recover the excess amount, by legal action if necessary.

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 any 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.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount that should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future Benefits.

Limitation of Action

You cannot bring any legal action against us or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in

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(Section 5: How to File a Claim) and all required reviews of your claim have been completed. 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.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

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Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

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Section 10: Glossary of Defined Terms

This section:

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

Alternate Facility - a health care facility that is not a Hospital, 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 Use Disorder Services on an outpatient or inpatient basis.

Amendment - any attached written description of additional or revised provisions or Benefits to the Plan. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

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

Annual Deductible - the amount you must pay for Covered Health Services in a calendar year before we will begin paying for Benefits in that calendar year. The actual amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses below.

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

BMI - a measure used in obesity risk assessment to determine the degree of obesity by approximating the measure of total body fat as compared with the assessment of body weight alone. Also referred to as Body Mass Index.

Certificate of Creditable Coverage - A document furnished by a group health plan or a health insurance company that shows the amount of time the individual has had coverage. This document is used to reduce or eliminate the length of time a preexisting condition exclusion applies.

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

Coinsurance – see Copayment

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

Congenital Heart Disease Resource Services - the Claims Administrator's program made available by the Employer to Employees. The Congenital Heart Disease Resource Services program provides information to Employees or their Covered

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Dependents with congenital heart disease and offers access to additional centers for the treatment of congenital heart disease.

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

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by Personal Health Support on our behalf.

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

A Covered Health Service is a health care service or supply described in Section 1: What's Covered--Benefits as a Covered Health Service, which is not excluded under Section 2: What's Not Covered--Exclusions, including Experimental or Investigational Services and Unproven Services.

Covered Health Services must be provided:

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

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.

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

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

Custodial Care - services that:

- Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent - the Retiree's legal spouse/Domestic Partner, as recognized by Washington State law, provided the spouse/domestic partner are under the age of 65 and not enrolled in one of the HEWT- sponsored medical/vision and dental Plans as an employee or retiree, or an unmarried Dependent child of the Retiree under the age of 23, if the Retiree provides more than fifty (50%) of the child's support and maintenance, provided the child is not 1) in active duty military service, 2) employed full-time, or 3) eligible for any other group health benefits through their employer.

Under the following circumstances, HEWT-sponsored health coverage can be continued upon reaching limiting age.

Your child is not able to be self-supporting by reason of mental retardation or a physical handicap, provided:

- the handicap existed before limiting age (see above), and
- the child was covered as a dependent prior to reaching limiting age, and
- the child is principally dependent on you for support, and

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- proof of the child's condition and dependence is submitted prior to the date coverage would otherwise have ended.

We may require that the child be examined by a physician chosen by us at our cost. You may be required to continue to provide proof that the child meets the conditions of incapacity and dependency. If you do not provide proof of the child's incapacity and dependency within 30 days of request, coverage for the child will end.

The Retiree 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 also includes a child for whom health care coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order. We are responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

A Dependent does not include anyone who is also enrolled as a Retiree. No one can be a Dependent of more than one person who is enrolled in a HEWT sponsored medical plan for employees or retirees.

Designated United Resource Network Facility - a Hospital that the Claims Administrator names as a Designated United Resource Network Facility. A Designated United Resource Network Facility has entered into an agreement with the Claims Administrator to render Covered Health Services for the treatment of specified diseases or conditions. To be considered a Designated Facility, a facility must meet certain standards of excellence and have a proven track record of treating specified conditions.

Domestic Partner - a person of the opposite or same sex with whom the Employee has established a domestic partnership as recognized/registered by Washington state law.

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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 Dependent or Eligible Dependent Child - a Dependent who has been continuously covered under a HEWT-sponsored health plan at the time of the Eligible Person's enrollment under this Plan.

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

Eligible Expenses are based on either of the following:

- When Covered Health Services are received from Network providers, Eligible Expenses are the contracted fee(s) with that provider.
- When Covered Health Services are received from non-Network providers, the Claims Administrator calculates Eligible Expenses based on available data resources of competitive fees in that geographic area, unless you received services as a result of an Emergency or as otherwise arranged through the Claims Administrator. In this case, Eligible Expenses are the fee(s) that are negotiated with the non-Network provider.

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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 - A former employee of a Sponsoring Employer who is under age 65, who retires from active service and at retirement is covered under a HEWT-sponsored group health plan. An Eligible Person must continuously meet the eligibility criteria set forth in the Plan Document, Summary Plan Description and Administrative Information, Hanford Retiree Welfare Benefit Plans.

Eligible Spouse – a spouse or Domestic Partner of an Eligible Person at the date the Eligible Person leaves active service who is covered under a HEWT-sponsored group health plan up to the date of enrollment in this Plan.

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

- Arises suddenly.

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

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

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

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

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exception:

- If you have a Sickness or condition likely to cause death within one year of the request for treatment we and the Claims

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Administrator may, at our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, we and the Claims Administrator must determine that although unproven the service has significant potential as an effective treatment for that Sickness or condition.

Health Statement(s) - a single, integrated statement that summarized EOB information by providing detailed content on account balances and claim activity.

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.

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

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.

MH/SUD (Mental Health/Substance Use Disorder)

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

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

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect 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 a Network provider for only some of our products. In this case, the provider will be a Network provider for the Health Services and products included in the participation agreement, and a non-Network provider for other Health Services and products. The participation status of providers will change from time to time.

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. The Plan Administrator will determine the period of time that is the Open Enrollment Period.

Out of Area Benefits - applies ONLY to retired employees under 65 (and their dependents) whose homes are NOT located in an area in which UnitedHealthcare network providers are available.

Out-of-Pocket Maximum - the maximum amount of Copayments you pay every calendar year. If you use both PPO Network Benefits and PPO Non-Network Benefits, two separate Out-of-Pocket Maximums apply. Depending on the geographic area and the service you receive, you may have access to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, your

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Coinsurance for Non-Network Benefits will remain the same, however the total amount that you owe may be less than if you received services from other non-Network providers because the Eligible Expenses may be a lesser amount.

Once you reach the Out-of-Pocket Maximum, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that calendar year.

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

- Any charges for non-Covered Health Services.
- Copayments for Covered Health Services available by an optional Rider.
- 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.
- The amount of any reduced Benefits if you don't notify Personal Health Support as described in Section 1: What's Covered--Benefits under the *Must You Notify Personal Health Support?* column.
- Charges that exceed Eligible Expenses.
- Any amounts applied towards meeting your Annual Deductible.

Even when the Out-of-Pocket Maximum has been reached, the following will not be paid at 100%:

- Any charges for non-Covered Health Services.
- The amount of any reduced Benefits if you don't notify Personal Health Support as described in Section 1: What's Covered--

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Benefits under the *Must You Notify Personal Health Support?* column.

- Charges that exceed Eligible Expenses.

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

Personal Health Support - programs provided by UnitedHealthcare that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

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

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

Plan – The Hanford Employee Welfare Trust (HEWT) “Options PPO for Retired Employees Under age 65” and the “Out-of-Area Plan for Hanford Retirees Under age 65”.

Plan Administrator - is the Hanford Employee Welfare Trust (HEWT) or its designee as that term is defined under ERISA.

Plan Sponsor - Hanford Employee Welfare Trust. References to "we", "us", and "our" throughout the SPD refer to the Plan Sponsor.

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

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

Pregnancy - includes all of the following:

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

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- no skilled services are identified;
- skilled nursing resources are available in the facility;
- the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose; or
- the service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

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

- It is established and operated in accordance with applicable state law for residential treatment programs.

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- It provides a program of treatment under the active participation and direction of a Physician and approved by the MH/SUD Administrator.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu.
 - room and board;
 - evaluation and diagnosis;
 - counseling; and
 - referral and orientation to specialized community resources.

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

Retiree - an Eligible Person who is properly enrolled under the Plan.

Rider - any attached written description of additional Covered Health Services not described in this SPD. Riders 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 SPD does not include Mental Illness or Substance

Use Disorder, regardless of the cause or origin of the Mental Illness or Substance Use Disorder.

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

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

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

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

- sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

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

UnitedHealth MyNurseSM - the primary nurse that may be assigned to you if you have a chronic or complex health condition. This nurse will call you to assess your progress, and provide you with information and education.

UnitedHealth Premium Program - a program that identifies Network Physicians or facilities that have been designated as a UnitedHealth Premium program Physician or facility for certain medical conditions.

Physicians and facilities must meet program criteria in order to be designated as a UnitedHealth Premium provider. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium program Physician or facility.

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, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we and the Claims Administrator must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

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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Attachment I

Women's Health and Cancer Rights Act of 1998

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

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

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

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

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

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 that 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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Attachment II

Summary Plan Description

Name of Plan: Hanford Employee Welfare Trust

Name of Employers sponsoring the Plan: A complete list of Employers sponsoring the Plan may be obtained by Participants and Beneficiaries upon written request to the Plan Administrator and is available for examination by Participants and Beneficiaries as required by Department of Labor Regulation Sections 2520.104b-1 and 2520.104b-30.

For a listing of the Employer Sponsors see the Wrapper document Schedule B posted on the HEWT home page.

Incumbent Employees are identified in the applicable prime contract with the Department of Energy or applicable subcontract agreement.

Name, Address and Telephone Number of Plan Administrator and Named Fiduciary:

Hanford Employee Welfare Trust
c/o Mission Support Alliance, LLC
P. O. Box 650, MSIN H2-23
Richland, WA 99352
(509) 372-8284

The Plan Administrator retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Administrator has

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delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

Employer Identification Number (EIN): 91-2017261

IRS Plan Number: 551

Effective Date of Plan: January 1, 2003; restatement January 1, 2010; restatement January 1, 2011; restatement January 1, 2014.

Type of Plan: Group health care coverage plan

Name, Business, Address, and Business Telephone Number of Trustees:

Trustees of the Hanford Employee Welfare Trust
c/o Mission Support Alliance, LLC
P. O. Box 650, MSIN H2-23
Richland, WA 99352
(509) 372-8284

Claims Administrator: The company which provides certain administrative services for the Plan.

United HealthCare Services, Inc. 185 Asylum Street, Hartford, CT
06103-3408

The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan.

Type of Administration of the Plan: The Plan Administrator provides certain administrative services in connection with its Plan. The Plan Administrator may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other

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administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of Benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. The Plan Administrator also has selected a Provider Network established by United HealthCare Services, Inc. The named fiduciary of Plan is Hanford Employee Welfare Trust, the Plan Administrator.

Person designated as agent for service of legal process: The name and address of the Agent for Service of Legal Process for the Plan is:

Jason T. Froggatt
Davis Wright Tremaine LLP
1201 Third Avenue
Suite 2200
Seattle, Washington 98101 – 3045

(426) 646-6128

Legal process may also be served upon a Plan Trustee or the Plan Administrator.

Source of contributions under the Plan: The sources of the contributions to the Plan are Employer and Employee contributions.

Method of calculating amount of contribution: Employee required contributions are determined by each Plan Sponsor. A schedule of such required contributions will be made available to eligible persons.

The Hanford Employee Welfare Trust is a funding medium through which benefits are provided.

Date of the end of the year for purposes of maintaining Plan's fiscal records: Plan year shall be a twelve month period ending December 31.

Determinations of Qualified Medical Child Support Orders: The Plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

Reservation of Rights to Amend or Terminate: Although each Plan Sponsor currently intends to continue the Benefits provided by this Plan, each Plan Sponsor reserves the right, at any time and for any reason or no reason at all, to change, amend, interpret, modify, withdraw or add Benefits or terminate this Plan or this Summary Plan Description, in whole or in part and in its sole discretion, without prior notice to or approval by Plan participants and their beneficiaries. Any change or Amendment to or termination of the Plan, its Benefits or its terms and condition, 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 termination), whether prospective or retroactive, to the Plan. The Amendment or resolution is effective only when approved by the body or person to whom such authority is formally granted by the terms of the Plan. No person or entity has any authority to make any oral changes or Amendments to the Plan.

Additional Information: Benefits under the Plan are furnished in accordance with the Plan Description issued by the Plan Administrator, including this Summary Plan Description.

Participant's rights under the Employee Retirement Income Security Act of 1974 (ERISA) and the procedures to be followed in regard to denied claims or other complaints relating to the Plan are set forth in the body of this Summary Plan Description.

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Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

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Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health Plan, if you have creditable coverage from another group health Plan. You should be provided a Certificate of Creditable Coverage in writing, free of charge, from your group health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. You may request a Certificate of Creditable Coverage by contacting the Plan Administrator. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court after all required reviews of your claim have been completed. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, United States Department of Labor listed in your

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telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, United States Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Pension and Welfare Benefits Administration.

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The benefits administered by United Healthcare are described above.

Please contact United Healthcare with any questions on these health benefits.

The ***Pharmacy Benefit Program*** described in the pages that follow below are relate to coverage administered by Express Scripts, Inc.

Please contact Express Scripts with respect to these pharmacy benefits.

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Prescription Drug Benefit Plan

Hanford Employee Welfare Trust (HEWT)

*Express Scripts, Inc. Providing Pharmacy benefits for
those enrolled in the “United HealthCare PPO” Medical
Plan*

for

Retired Employees Under 65

Effective Date: January 1, 2014

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Prescription Drug Benefits

A separate Pharmacy Benefit Program covers prescription drugs. United Healthcare does not administer the prescription drug portion of this retiree medical plan. This program is administered by Express Scripts. There are two ways you can purchase prescription drugs, from a participating **retail** pharmacy or by using **mail order**. This Prescription Program in effect as of January 1, 2014, and administered by Express Scripts, is briefly described below. More details of the program are available directly from Express Scripts.

Your Share of the Cost (Co-payments)

Both the mail and the retail programs have three-tier co-payment structures. When you purchase a prescription, your cost will be the required co-payment (or you can pay the actual cost of the drug, if it is less than the applicable co-payment amount). The co-payment depends on the category of the drug, and whether it is from retail or mail order.

The three categories, or tiers, are:

Generic: Drugs in which the patent has expired, allowing other manufacturers to produce and distribute the product under a generic name. Generics are essentially a chemical copy of their brand-name equivalents. The color or shape may be different, but the active ingredients must be the same for both.

Preferred Brand Name: A drug with a trade name under which the product is advertised and sold, and is protected by patents so that it can only be produced by one manufacturer for 7 years.

Non-Preferred Brand Name: A brand medication that has been reviewed by a Pharmacy and Therapeutics committee (physicians and pharmacists) who determine that an alternative drug that is clinically equivalent and more cost effective is available.

Your druggist can determine the category of a drug, or you can contact Express Scripts by calling their toll-free Customer Service line **(1-800-796-7518)**, or via the internet at

www.express-scripts.com.

The following features are applicable to Retail AND to Mail Order:

- There is an annual *maximum out-of-pocket limit of \$1,500* per member. Both mail order and retail co-payment amounts apply in the calculation.
- There is **NO Deductible**. Prior to August 1, 2001, there was a \$50 per person/\$150 per family annual deductible for retail prescriptions, only.
- Co-payment amounts for both mail order and retail prescriptions are in effect as of January 1, 2014. These are subject to change.
- There are no replacement prescriptions allowable under the plan.
- Quantity limits may apply to some drugs. These are determined by the manufacturer and are subject to change. Most prescription drugs are available to you under the Plan. They will be dispensed as written by the physician. However, you will pay more out-of-pocket if you request a brand-name drug when the prescription is written for a generic drug.

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What's Not Covered—Pharmacy

Exclusions:

Drugs that are **NOT** covered by the plan include, but are not limited to, the following:

- multiple vitamins (including vitamins with fluoride)
- prenatal vitamins
- appetite suppressants
- injectable drugs (Certain injectable drugs are covered. Contact Express Scripts for specific information)
- medications for cosmetic purposes (e.g. Rogaine)
- medications with no FDA indications (e.g. yohimbine)
- nystatin oral powder
- oral contraceptives
- injectable contraceptives (e.g. Depo-Provera)
- diaphragms
- progesterone products (including compounded forms)
- over-the-counter (OTC) medications or products equivalent to OTC medications
- vitamin B12
- smoking deterrents
- anorexiant or other drugs used for weight control
- DESI drugs (drugs determined by the Food and Drug Administration to lack substantial evidence of effectiveness)
- drugs labeled “Caution – limited by federal law to investigational use” or experimental drugs

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- therapeutic devices or appliances, support garments and other non-medical substances
- immunizing agents, biologicals, blood and blood plasma
- Accutane (Isotretinoin)
- all forms of Retin A
- all “over-the-counter” drugs not needing a prescription.

Prescription Drug Review

Some prescription drugs require a “prescription drug review” or prior authorization before they may be covered by the Plan. If your pharmacist tells you that your prescription drug requires prior authorization, ask your pharmacist or your doctor to call Express Scripts.

Customer Service Center

The Express Scripts Customer Service Call Center is available 24 hours a day, 365 days a year to help you locate a participating pharmacy or to help you better understand and use your program. To reach the call center or a pharmacist, call toll-free: **1-800-796-7518**. (TDD for hearing impaired: **1-800-899-2114**, or **1-612-797-4566**).

In an emergency, a pharmacist can be reached 24 hours a day at 1-800-626-6080.

Claim and Appeal Procedure

If you are not satisfied with the disposition of your claim for benefits under the Pharmacy Benefit Program, you have the right to appeal to the Plan Administrator. Your appeal should be filed with the Plan Administrator within 60 days of the denial of your claim by Express Scripts. For the appeal procedure, see the Plan Document,

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Summary Plan Description and Administrative Information, Hanford Retiree Welfare Benefit Plans (Administrative Wrapper). A copy of the Administrative Wrapper may be obtained without charge by contacting Mission Support Alliance, LLC Benefits Administration or via the internet at www.hanford.gov/hr.

Coordination of Benefits (COB)

The coordination of benefits provision described in the Medical Plan above, Section 7, Coordination of Benefits (COB) does not apply to covered Prescription Drugs as described in this section. However, the definitions provided in that section apply here as do the Order of Benefit Determination Rules. This Coordination of Benefits provision applies only when a person has prescription drug coverage under more than one benefit plan.

Following the Order of Benefit Determination Rules described above in Section 7 determines which Coverage Plan will pay as the Primary Coverage Plan when a person has prescription drug coverage under more than one benefit plan. The Primary Coverage Plan that pays first pays without regard 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. However, if this Coverage Plan is the Secondary Coverage Plan, it will not pay any benefits.

Other Coordination of Benefits provisions described in the Medical Plan above in Section 7 are unchanged.

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Retail Prescription Program

Express Scripts offers retail prescription coverage at over 43,000 participating pharmacies nationwide, excluding Walgreens. Check with your pharmacy to see if they are an Express Scripts participant, or contact Express Scripts Customer Service for help in locating a participating pharmacy in your area.

Your Cost

The Retail Prescription Program allows you to purchase up to a 34-day supply for a co-payment. Quantity limits may apply based on type of medication prescribed.

The following co-payments apply to prescriptions purchased from a participating retail pharmacy:

<u>Category</u>	<u>Co-Payment</u>
Generic Drugs	\$15.00
Preferred Brand-Name	\$35.00
Non-Preferred Brand-Name	\$50.00

Purchasing Prescriptions

At a Participating Retail Pharmacy -

When you purchase a prescription under this plan, you simply present your identification card (provided to you by Express Scripts) and co-payment amount. No claim forms are required after co-payment is made.

At a Retail Pharmacy that is not participating with Express Scripts -

You can also purchase a drug at a non-participating pharmacy. You should pay for the prescription, then submit a claim for reimbursement from Express Scripts.

However, if you do, your reimbursement will be based on the Express Scripts in-network contracted rate for that drug, less the required co-payment.

You will have to pay the difference between the price charged by the non-network pharmacy and the Express Scripts contracted rate in addition to the applicable co-payments.

For non-network retail purchases, complete an Express Scripts claim form and submit your claim and receipts to:

ATTN: Standard Accounts
P.O. Box 66583390873
St. Louis, MO 63166-6583

Claim forms for out-of-network purchases can be requested from the Express Scripts web site, www.express-scripts.com, or by calling Customer Service at 1-800-796-7518.

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Mail Order Drug Program

Another option for obtaining prescriptions is the Mail Order Drug Program, which allows you to purchase up to a 90-day supply of most prescription drugs for a single co-payment. The mail order pharmacy program is also administered by Express Scripts. The Mail Order program works best for drugs that you take on a long-term basis (“maintenance drugs.”). Most prescribed drugs. Certain drugs are not available by mail order. Contact Express Scripts Customer Service for more information.

Your Cost

The following co-payments apply to prescriptions purchased from the Express Scripts Mail Order program.

<u>Category</u>	<u>Co-Payment</u>
Generic Drugs	\$30.00
Preferred Brand-Name	\$70.00
Non-Preferred Brand-Name	\$100.00

Purchasing Mail-Order Prescriptions

Ask your physician to prescribe needed medication for up to a 90-day supply, plus refills. If you, or your Eligible Dependents, are presently taking medication, ask your doctor for a new prescription. Complete the patient profile questionnaire with your first order. Answer all questions and be sure to include your Social Security number on the form.

You can contact Express Scripts for the necessary mail order form and other information for the necessary form and for other information.

Send the completed mail order form along with your prescription written for 90 days and your applicable co-payment. You can submit multiple prescriptions in one envelope; just be sure to include a co-payment for each prescription. Contact Customer Service to determine which category your prescription is: generic, preferred brand-name or non-preferred brand-name.

Your prescriptions will be filled and returned to you at the address you have specified on your order form. If you need to change the address, please call the toll-free “800” number listed on your order form, or you can change the address on the form itself.

Most prescription orders take 14 days to be filled and returned to you unless there are mail delays. If you need a supply of medication while waiting for your mail order prescription, ask your doctor for two prescriptions, so you can get a small supply of medication from your local pharmacy while awaiting your Express Scripts prescription.

Once your Express Scripts Mail Order facility has processed your first prescription, you can order approved refills either by mail or on the internet at www.express-scripts.com.

Any time you have questions on your medication(s), you can call the Customer Service Department and talk to a pharmacist. Their toll-free number is: **1-800-796-7518**.

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