Summary Plan Description

Choice Plus

for

Officials Elected Post April, 2011 of

Franklin County Board of Commissioners

Group Number: 741964
Effective Date: April 1, 2012

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Introduction

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

How to Use this Document

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

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

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

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

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

Information about Defined Terms

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

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

Your Contribution to the Benefit Costs

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

Customer Service and Claims Submittal

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

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

Prior Notification: As shown on your ID card.

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

Claims Submittal Address:

United Healthcare Services, Inc.
Attn: Claims
P.O. Box 981504
El Paso, Texas 79998-1504

Requests for Review of Denied Claims and Notice of Complaints:

Name and Address For Submitting Requests:

United Healthcare Services, Inc.
P.O. Box 30432
Salt Lake City, Utah 84130-0432

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Section 1: What's Covered—Benefits

This section provides you with information about:

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

Accessing Benefits

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

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

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

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

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

Copayment

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

Eligible Expenses

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

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

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

Notification Requirements

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

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

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

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

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

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

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

Special Note Regarding Medicare

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

Payment Information

Payment Term	Description	Amounts
Annual Deductible	The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. There are separate Network and non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year. 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).	***Network*** $200 per Covered Person per Plan year, $400 per Employee and one Dependent not to exceed $500 for all Covered Persons in a family. Employee Only - $200 Employee + 1 Dependent - $400 Employee + Family - $500 ***Non-Network*** $400 per Covered Person per Plan year, , $800 per Employee and one Dependent not to exceed $1,000 for all Covered Persons in a family. Employee Only - $400 Employee + 1 Dependent - $800 Employee + Family - $1,000
Out-of-Pocket Maximum	The maximum you pay, out of your pocket, in a Plan year for Copayments. For a complete definition of Out-of-Pocket Maximum, see (Section 10: Glossary of Defined Terms).	***Network*** $600 per Covered Person per Plan year, $1,200 per Employee and one Dependent not to exceed $1,500 for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible. Employee Only - $600 Employee + 1 Dependent - $1,200 Employee + Family - $1,500 ***Non-Network*** $1,200 per Covered Person per Plan year, $2,400 per Employee and one

Payment Term	Description	Amounts
		Dependent not to exceed $3,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible. Employee Only - $1,200 Employee + 1 Dependent - $2,400 Employee + Family - $3,000
Maximum Plan Benefit	There is no **dollar** limit to the amount the Plan will pay for **essential** Benefits during the entire period you are enrolled in this Plan.	No Maximum Plan Benefit

Benefit Information

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
1. Ambulance Services - Emergency only Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.	***Network*** No	*Ground Transportation:* 0% *Air Transportation:* 0%	Yes	Yes
	Non-Network No	Same as Network	Same as Network	Same as Network
Non-Emergency The Plan also covers transportation provided by licensed professional ambulance, other than air ambulance, (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is: • From a non-Network Hospital to a Network Hospital; • To a Hospital that provides a higher level of care that was not available at the original Hospital; • To a more cost-effective acute care facility; or • From an acute facility to a sub-acute setting.	***Network*** No	*Ground Transportation:* 0% *Air Transportation:* 0%	No	Yes
	Non-Network Yes	Same as	Same as	Same as

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
		Network	Network	Network
2. Cancer Resource Services We will arrange for access to certain of our Network providers that participate in the Cancer Resource Services program for the provision of oncology services. We may refer you to Cancer Resource Services, or you may self refer to Cancer Resource Services by calling 866-936-6002. In order to receive the highest level of Benefits, you must contact Cancer Resource Services prior to obtaining Covered Health Services. The oncology services include Covered Health Services and supplies rendered for the treatment of a condition that has a primary or suspected diagnosis relating to cancer. In order to receive Benefits under this program, Cancer Resource Services must provide the proper notification to the Network provider performing the services. This is true even if you self refer to a Network provider participating in the program. When these services are not performed in a Cancer Resource Services facility, Benefits will be paid the same as Benefits for *Hospital-Inpatient Stay*, *Outpatient Surgery*, *Diagnostic and Therapeutic Services*, *Physician's Office Services*, and *Professional Fees for Surgical and Medical Services* stated in this (Section 1: What's Covered--Benefits). **Transportation and Lodging** A Cancer Resource Services nurse consultant will assist the patient and family with travel and lodging arrangements. Expenses for travel and lodging for the Covered Person receiving cancer-related	***Network*** Cancer Resource Services must be called.	0%	Yes	Yes
	Non-Network Non-Network Benefits for the Cancer Resource Services program are not available.	Non-Network Benefits for the Cancer Resource Services program are not available.	Non-Network Benefits for the Cancer Resource Services program are not available.	Non-Network Benefits for the Cancer Resource Services program are not available.

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
treatment associated with the Cancer Resource Services program, and a companion are available under the Plan as follows: • Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site where services are given for the purposes of an evaluation, the procedure or other treatment, or necessary post-discharge follow-up. • Reasonable and necessary 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 patient resides more than 50 miles from the Designated Facility. • If the patient is an Enrolled Dependent minor child, Benefits for the transportation expenses of two companions will be provided and lodging expenses will be reimbursed up to the $100 per diem rate. There is a combined overall lifetime maximum of $10,000 per Covered Person for all transportation and lodging expenses incurred by the patient and companion(s) and reimbursed under the Plan in connection with all transplant procedures or cancer-related services.				
3. Dental Services - Accident only Dental services when all of the following are true: • Treatment is necessary because of accidental damage.	***Network*** Yes	0%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• 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. 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 the Claims Administrator** Please remember that you must notify the Claims Administrator as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. (You do not have to provide	***Non-Network*** Yes	20%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
notification before the initial Emergency treatment.) If you don't notify the Claims Administrator, Benefits will be reduced to 50% of Eligible Expenses.				
4. Dental Services – Hospital or Outpatient Surgery Services Hospital or outpatient surgery center charges provided in conjunction with dental care, including anesthetics, if a dentist and a Physician determine that hospitalization or general anesthesia is required for dental care because: • The Covered Person is a child under the age of 5 or • The Covered Person has a chronic disability that prevents effective treatment in a dental office or • The Covered Person has a medical condition that prevents effective treatment in a dental office.. Coverage does not include expenses for the diagnosis and treatment of dental disease. **Notify the Claims Administrator** Please remember that you must notify the Claims Administrator as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. (You do not have to provide notification before the initial Emergency treatment.) If you don't notify the Claims Administrator, Benefits will be reduced to 50% of Eligible Expenses.	***Network*** Yes	0%	No	Yes
	Non-Network Yes	20%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
5. Durable Medical Equipment Durable Medical Equipment that meets each of the following criteria: • Ordered or provided by a Physician for outpatient use. • Used for medical purposes. • Not consumable or disposable. • Not of use to a person in the absence of a disease or disability. If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment. Examples of Durable Medical Equipment include: • Equipment to assist mobility, such as a standard wheelchair. • A standard Hospital-type bed. • Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks). • Delivery pumps for tube feedings (including tubing and connectors). • Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part 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	***Network*** No ***Non-Network*** Yes, for items more than $1,000.	0% 20%	Yes Yes	Yes Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
devices, and are excluded from coverage. Dental braces are also excluded from coverage. • Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage). • Foot Orthotics and fittings. We provide Benefits only for a single purchase (including repair/ replacement) of a type of Durable Medical Equipment once every three Plan years. We and the Claims Administrator will decide if the equipment should be purchased or rented. To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor the Claims Administrator identifies. **Notify the Claims Administrator** Please remember that for Non-Network Benefits you must notify the Claims Administrator before obtaining any single item of Durable Medical Equipment that costs more than $1,000 (either purchase price or cumulative rental of a single item). If you don't notify the Claims Administrator, you will be responsible for paying all charges and no Benefits will be paid.				
6. Emergency Health Services Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an	***Network*** No	$150 per visit	No	No

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
outpatient basis at a Hospital or Alternate Facility. You will find more information about Benefits for Emergency Health Services in (Section 3: Description of Network and Non-Network Benefits). **Notify the Claims Administrator** Please remember that if you are admitted to a non-Network Hospital as a result of an Emergency, you must notify the Claims Administrator within one business day or the same day of admission, or as soon as reasonably possible. If you don't notify the Claims Administrator as required, your Benefits will be reduced as described below under *Hospital - Inpatient Stay*.	***Non-Network*** No	Same as Network	Same as Network	Same as Network
7. Eye Examinations Eye examinations received from a health care provider in the provider's office. Benefits for the diagnosis and treatment of a Sickness or Injury are not limited.	***Network*** No	$20 per visit	No	No
Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.	***Non-Network*** No	20%	Yes	Yes
8. Hearing Aids 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	***Network*** No	0%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver. Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing. Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following: • craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or • hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid. Any combination of Network Benefits and Non-Network Benefits is limited to $1,000 per year. Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every three Plan years.	***Non-Network*** No	20%	Yes	Yes
9. Home Health Care Services received from a Home Health Agency that are both of the following: • Ordered by a Physician.	***Network*** No	0%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Provided by or supervised by a registered nurse in your home. Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required. Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true: • It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified 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. We and the Claims Administrator will decide if skilled care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver. Any combination of Network and Non-Network Benefits is limited to 120 visits per Plan year. One visit equals four hours of skilled care	***Non-Network*** Yes	20%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
services. **Notify the Claims Administrator** Please remember that for Non-Network Benefits you must notify the Claims Administrator five business days before receiving services. If you don't notify the Claims Administrator, Benefits will be reduced to 50% of Eligible Expenses.				
10. Hospice Care Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed hospice agency. Please contact the Claims Administrator for more information regarding guidelines for hospice care. You can contact the Claims Administrator at the telephone number on your ID card. **Notify the Claims Administrator** Please remember that for Non-Network Benefits you must notify the Claims Administrator five business days before receiving services. If you don't notify the Claims Administrator, Benefits will be reduced to 50% of Eligible Expenses.	***Network*** No ***Non-Network*** Yes	0% 20%	No Yes	No Yes
11. Hospital - Inpatient Stay	***Network*** No	0%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Inpatient Stay in a Hospital. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). Benefits for Physician services are described under *Professional Fees for Surgical and Medical Services.* **Notify the Claims Administrator** Please remember that for Non-Network Benefits you must notify the Claims Administrator as follows: • For elective admissions: five business days before admission. • For non-elective admissions: within one business day or the same day of admission. • For Emergency admissions: as soon as reasonably possible. If you don't notify the Claims Administrator, Benefits will be reduced to 50% of Eligible Expenses.	***Non-Network*** Yes	20%	Yes	Yes
12. Infertility Services Services for the treatment of infertility when provided by or under the direction of a Physician. The following reproductive services are excluded: • Artificial insemination. • In vitro fertilization.	***Network*** No	0%	N/A	Yes
	Non-Network No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Gamete intrafallopian transfer (GIFT) procedures. • Zygote intrafallopian transfer (ZIFT) procedures. • Embryo transport. • Donor ovum and semen and related costs including collection and preparation. • Experimental, Investigational or Unproven Services for the treatment of infertility				
13. Injections received in a Physician's Office Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.	***Network*** No	0% per injection	No	No
	Non-Network No	20% per injection	Yes	Yes
14. Maternity Services				
Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery,	***Network*** No	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Surgery, Diagnostic and Therapeutic Services.		

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
and any related complications. There are special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the programs. To sign up, you should notify the Claims Administrator during the first trimester, but no later than one month prior to the anticipated childbirth. We will pay Benefits for an Inpatient Stay of at least: • 48 hours for the mother and newborn child following a normal vaginal delivery. • 96 hours for the mother and newborn child following a cesarean section delivery. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. **Notify the Claims Administrator** Please remember that for Non-Network Benefits you must notify the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described. If you don't notify the Claims Administrator that the Inpatient Stay will be extended, your Benefits for the extended stay will be reduced to 50% of Eligible Expenses.	***Non-Network*** Yes, if Inpatient Stay exceeds time frames.	No Copayment applies to Physician office visits for prenatal care after the first visit. Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Surgery, Diagnostic and Therapeutic Services.		
15. Morbid Obesity Surgery Weight loss surgery includes but is not limited to gastric bypass,	***Network*** Yes	$1,700	N/A	No

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
gastric banding and gastric reduction. Limited to 1 surgery per lifetime.		Deductible		
	Non-Network Non-Network Benefits for the Bariatric Surgery are not available	Non-Network Benefits for the Bariatric Surgery are not available	Non-Network Benefits for the Bariatric Surgery are not available	Non-Network Benefits for the Bariatric Surgery are not available
To Be Considered All Criteria Must Be Met: — BMI over 40 (or over 35 with two imminently life-threatening co morbid conditions directly related to obesity) — Letter from the Franklin County Cooperative Health Benefit Program confirming two years enrollment in the Cooperative. — All procedures will be performed by the following facilities: The Ohio State University Medical Center Bariatric Program, Fresh Start Bariatrics at Riverside Methodist Hospital, Mount Carmel Bariatric Surgery Program, in accordance with these benefit guidelines. — Six-month weight loss effort medically documented and supervised by the patient's treating physician. A minimum of one physician visit per month for six consecutive months is required and must be documented. — Mental health clinician's statement of member having completed an appropriate behavioral health evaluation per Hospital				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
program. — Patients must be at least 25 years old. Please note that the member must adhere to the criteria listed above for morbid obesity surgery to be covered by the Plan. The member may also be required to meet specific criteria that are set forth by the specific facility in which the member is having surgery and any associated costs. Lap band adjustment benefit available as described under sections 11. Hospital Inpatient Stay, 18. Outpatient Surgery, Diagnostic and Therapeutic Services, and 20. Professional Fees for Surgical and Medical Services.				
EXCLUSIONS The following are not ever covered benefits associated with weight loss: — Liposuction — Administrative fee charged by individual program — Liquid or solid food supplements — Exercise programs — Exercise equipment — Nutritional classes — Individual dietician visits				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
16. Nutritional Education Health Services provided on an outpatient basis for nutrition education for a Covered Person with diabetes.	***Network*** No	0%	Yes	Yes
	Non-Network No	20%	Yes	Yes
17. Ostomy Supplies Benefits for ostomy supplies include only the following: • Pouches, face plates and belts. • Irrigation sleeves, bags and catheters. • Skin barriers. Benefits are not available for gauze, adhesive, adhesive remover, deodorant, pouch covers, or other items not listed above.	***Network*** No	0%	Yes	Yes
	Non-Network No	20%	Yes	Yes
18. Outpatient Surgery, Diagnostic and Therapeutic Services				
Outpatient Surgery Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including: Benefits under this section include only the facility charge and the charge for required Hospital-based professional services, supplies and equipment. Benefits for the surgeon fees related to outpatient	***Network*** No	0%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
surgery are described under *Professional Fees for Surgical and Medical Services*.				
When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.	***Non-Network*** No	20%	Yes	Yes
Outpatient Diagnostic Services Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including: • Lab and radiology/X-ray. • Mammography testing. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below. This section does not include Benefits for CT scans, PET scans, MRIs, or nuclear medicine, which are described immediately below.	***Network*** No No ***Non-Network*** No	***For preventive diagnostic services:*** No Copayment ***For mammography testing:*** 0% if not in conjunction with office visit; $20 if in conjunction with a office visit 20%	Yes No Yes	Yes No Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	***Network*** No	0%	Yes	Yes
Covered Health Services for CT scans, PET scans, MRI, and nuclear medicine received on an outpatient basis at a Hospital or Alternate Facility.				
Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.	***Non-Network*** No	20%	Yes	Yes
Outpatient Therapeutic Treatments	***Network*** No	0%	No	No
Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.				
Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.	***Non-Network*** No	20%	Yes	Yes
When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.				
19. Physician's Office Services **Covered Health Services for preventive medical care.**	***Network*** No	0%	No	No
Preventive care services provided on an outpatient basis at a				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law: • Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force. • Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. • With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. • With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.Voluntary family planning.				
	Non-Network No	0%	Yes	Yes
Covered Health Services for the diagnosis and treatment of a Sickness or Injury received in a Physician's office.	***Network*** No	$20 per visit Includes:	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
		All Primary Care Physicians $20 Specialist Not - rated by Premium Designated Program $20 -2 star rated Premium Designated Specialists $20 - Non Premium Designated Specialist – $40 Includes: - 1 star rated Specialists $40 - 0 star rated Specialists $40 - Insufficient Info Specialists $40		
	Non-Network			
	No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
20. Professional Fees for Surgical and Medical Services Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.	***Network*** No	0%	Yes	Yes
When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.	***Non-Network*** No	20%	Yes	Yes
21. Prosthetic Devices External prosthetic devices that replace a limb or an external body part, limited to: • Artificial arms, legs, feet and hands. • Artificial eyes, ears and noses. • Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.	***Network*** No	0%	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. Except for items required by the Women's Health and Cancer Rights Act of 1998, Benefits for prosthetic	***Non-Network*** No	20%	Yes	Yes

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

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Covered Health Service. You can contact the Claims Administrator at the telephone number on your ID card for more information about Benefits for mastectomy-related services. **Notify the Claims Administrator** Please remember that for Non-Network Benefits you should notify the Claims Administrator five business days before receiving services to verify that they are Covered Health Services for which Benefits are available. When reconstructive procedures are provided on an inpatient basis, you must notify the Claims Administrator as described above under *Hospital - Inpatient Stay*. If you don't notify the Claims Administrator as required, your Benefits will be reduced as described under *Hospital - Inpatient Stay*.				
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. Benefits under this section include rehabilitation services provided in a Physician's office	***Network*** No ***Non-Network*** No	$20 per visit 20%	No Yes	No Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
or on an outpatient basis at a Hospital or Alternate Facility. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment. Please note that we will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly. Any combination of Network and Non-Network Benefits is limited as follows: • 25 visits of physical therapy per Plan year. • 25 visits of occupational therapy per Plan year. • 25 visits of speech therapy per Plan year. • 25 visits of pulmonary rehabilitation therapy per Plan year. • 25 visits of cardiac rehabilitation therapy per Plan year.				
24. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds).	***Network*** No	0%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Any combination of Network and Non-Network Benefits is limited to 100 days for Skilled Nursing Facility, and 45 days for Inpatient Rehabilitation Facility per Plan year. Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital. **Notify the Claims Administrator** Please remember that for Non-Network Benefits you must notify the Claims Administrator as follows: • For elective admissions: five business days before admission. • For non-elective admissions: within one business day or the same day of admission. • For Emergency admissions: as soon as reasonably possible. If you don't notify the Claims Administrator, Benefits will be reduced to 50% of Eligible Expenses.	***Non-Network*** Yes	20%	Yes	Yes
25. Skin Excision	***Network*** Yes	$1,000 deductible, once per time per lifetime, followed by annual deductible	No	No

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Based on Medical Necessity Any combination of Network and Non-Network Benefits is limited to a Maximum of $6,000 per lifetime. **Notify the Claims Administrator** Please remember that for Non-Network Benefits you must notify the Claims Administrator before receiving Benefits). If you don't notify the Claims Administrator, you will be responsible for paying all charges and no Benefits will be paid.	***Non-Network*** Yes	$1,000 deductible once per lifetime, followed by annual deductible, plus 20%	Yes	Yes
26. Spinal Treatment Benefits for Spinal Treatment when provided by a Spinal Treatment provider in the provider's office.	***Network*** No	$20 per visit	No	No
Benefits include diagnosis and related services and are limited to one visit and treatment per day. Any combination of Network and Non-Network Benefits for Spinal Treatment is limited to 25 visits per Plan year.	***Non-Network*** No	20%	Yes	Yes
27. Transplantation Services Covered Health Services for organ and tissue transplants when ordered by a Physician. Transplantation services must be received at a Designated Facility. Benefits are available when the transplant meets the definition of a Covered Health Service, and is not an Experimental, Investigational or Unproven Service:	***Network*** Yes	0%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Examples of transplants for which Benefits are available include but are not limited to: • Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. • Heart transplants. • Heart/lung transplants. • Lung transplants. • Kidney transplants. • Kidney/pancreas transplants. • Liver transplants. • Liver/small bowel transplants. • Pancreas transplants. • Small bowel transplants. Benefits are also available for cornea transplants that are provided by a Network Physician at a Network Hospital. We do not require that cornea transplants be performed at a Designated Facility. For cornea transplants, Benefits will be paid at the same level as *Professional Fees for Surgical and Medical Services*, *Outpatient Surgery*, *Diagnostic and Therapeutic Services*, and *Hospital - Inpatient Stay* rather than as described in this section *Transplantation Services*. Organ or tissue transplants or multiple organ transplants other than	***Non-Network*** Non-Network Benefits are not available.	Non-Network Benefits are not available.	Non-Network Benefits are not available.	Non-Network Benefits are not available.

those listed above are excluded from coverage.

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

Transportation and Lodging

The Claims Administrator will assist the patient and family with travel and lodging arrangements when services are received from a Designated Facility. Expenses for travel 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 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.

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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 reimbursed under this Plan in connection with all transplant procedures. **Notify the Claims Administrator** You must notify the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you do not notify the Claims Administrator, and if the transplantation services are not performed at a Designated Facility, you will be responsible for paying all charges and Benefits will not be paid. Please remember that you must notify United Resource Networks or Care Coordination℠ as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If United Resource Networks or Care Coordination℠ is not notified and if, as a result, the services are not performed at a Designated Facility, no Benefits will be paid and you will be responsible for paying all charges.				
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.	***Network*** No	$25 per visit	No	No

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
	Non-Network No	20%	Yes	Yes
29. Vasectomy and Tubal Ligation Services Services and supplies for vasectomy and tubal ligation procedures provided in a Physician's office, Alternate Facility or Hospital.	***Network*** No	0%	No	No
	Non-Network 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.

We Do not Pay Benefits for Exclusions

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

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

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

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

A. Alternative Treatments

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

B. Comfort or Convenience

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

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

C. Dental

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

D. Drugs

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

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

E. Experimental, Investigational or Unproven Services

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

F. Foot Care

1. Routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes. Routine foot care services that are not covered include:
   - — Cutting or removal of corns and calluses.
   - — Nail trimming or cutting.
   - — Debriding (removal of dead skin or underlying tissue).
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.
4. Treatment of subluxation of the foot.

G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.

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

2. Prescribed or non-prescribed medical supplies and disposable supplies except for outpatient medical supplies for the treatment of Sickness or Injury when such supplies are used to serve a medical purpose including, but not limited to: surgical dressings, catheters, splints, Aerochambers, Inspirease and Breathancers.
   - Examples of excluded supplies include:
   - Items usually stocked in the home for general use such as:
     -Elastic or adhesive bandages,
     -Thermometers or
     -Petroleum jelly
   - Elastic stockings.
   - Ace bandages.
   - Gauze and dressings.
3. Orthotic appliances that straighten or re-shape a body part except as described under *Durable Medical Equipment (DME)* in (Section 1: What's Covered—Benefits).

   Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any orthotic braces available over-the-counter.
4. Cranial banding.
5. Tubings and masks are not covered except when used with *Durable Medical Equipment* as described in (Section 1: What's Covered--Benefits).

H. Mental Health/Substance Use Disorder

Exclusions listed directly below apply to services described in (Section 1: What's Covered – Benefits).

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

1. Services for the treatment of mental illness or mental health conditions, substance use disorder services and autism spectrum disorders as the primary diagnosis that the Plan Sponsor has elected to provide through a separate benefit Plan. (Autism spectrum disorders are a group of neurobiological disorders that includes *Autistic Disorder*, *Rhett's Syndrome*, *Asperger's Disorder*, *Childhood Disintegrated Disorder* and *Pervasive Development Disorders Not Otherwise Specified (PDDNOS)*).

I. Nutrition

1. Megavitamin and nutrition based therapy.
2. Nutritional counseling for either individuals or groups except as specifically described in (Section 1: What's Covered--Benefits).
3. Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, even if they are the only source of nutrition and even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded;
   - 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.
4. Health education classes unless offered by United HealthCare Services, Inc. or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

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

J. Physical Appearance

1. Cosmetic Procedures. See the definition in (Section 10: Glossary of Defined Terms). Examples include:
   - — Pharmacological regimens, nutritional procedures or treatments.
   - — Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - — Skin abrasion procedures performed as a treatment for acne.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.
   Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in (Section 1: What's Covered--Benefits).
3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
5. Wigs regardless of the reason for the hair loss.

K. Providers

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

   This exclusion does not apply to mammography testing.

L. Reproduction

1. In vitro fertilization, gamete intrafallopian transfer (GIFT) procedures, and zygote intrafallopian transfer (ZIFT) procedures.
2. Surrogate parenting.
3. The reversal of voluntary sterilization.
4. Health services and associated expenses for elective abortion.
5. Fetal reduction surgery.
6. Health services associated with the use of non-surgical or drug-induced Pregnancy termination.

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.

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

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

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, multiple organ and tissue transplants, except as described in (Section 1: What's Covered--Benefits) unless the Claims Administrator determines the transplant to be appropriate according to the Claims Administrator's transplant guidelines.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan).
3. Health services for transplants involving mechanical or animal organs.
4. Transplant services that are not performed at a Designated Facility.
5. Any solid organ transplant that is performed as a treatment for cancer.
6. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Services* in (Section 1: What's Covered--Benefits).

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

O. Travel

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

P. Vision and Hearing

1. Purchase cost of eye glasses or contact lenses.
2. Fitting charge for eye glasses or contact lenses.
3. Eye exercise therapy.
4. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

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.

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3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
4. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
6. In the event that a non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments and/or Annual Deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.
9. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.
10. Non-surgical treatment of obesity, excluding morbid obesity.
11. Surgical treatment of obesity, excluding morbid obesity.
12. Growth hormone therapy, except for Network services.
13. Sex transformation operations.
14. Custodial Care.
15. Domiciliary care.
16. Private duty nursing.
17. Respite care.
18. Rest cures.

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

19. Psychosurgery.
20. Treatment of benign gynecomastia (abnormal breast enlargement in males).
21. Medical and surgical treatment of excessive sweating (hyperhidrosis).
22. Panniculectomy, abdominoplasty, thighplasty, brachioplasty, mastopexy, and breast reduction, or unless medically necessary. This exclusion does not apply to breast reconstruction following a mastectomy as described under *Reconstructive Procedures* in (Section 1: What's Covered--Benefits).
23. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
24. Oral appliances for snoring.
25. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly.
26. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
27. Any charge for services, supplies or equipment advertised by the provider as free.
28. Any charges prohibited by federal anti-kickback or self-referral statutes.

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

Section 3: Description of Network and Non-Network Benefits

This section includes information about:

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

Network Benefits

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

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

Comparison of Network and Non-Network Benefits

	Network	Non-Network
Benefits	A higher level of Benefits means less cost to you. See (Section 1: What's Covered--Benefits).	A lower level of Benefits means more cost to you. See (Section 1: What's Covered--Benefits).
Who Should Notify the Claims Administrator for Care Coordination℠	Network providers generally handle notification for you. However, there are exceptions. See (Section 1: What's Covered--Benefits), under the *Must You Notify the Claims Administrator?* column.	You must notify the Claims Administrator for certain Covered Health Services. Failure to notify results in reduced Benefits or no Benefits. See (Section 1: What's Covered--Benefits), under the *Must You Notify the Claims Administrator?* column.
Who Should File Claims	Not required. We pay Network providers directly.	You must file claims. See (Section 5: How to File a Claim).
Outpatient Emergency Health Services	Emergency Health Services are always paid as a Network Benefit (paid the same whether you are in or out of the Network). That means that if you seek Emergency care at a non-Network facility, you are not required to meet the Annual Deductible or to pay any difference between Eligible Expenses and the amount the provider bills.	

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Provider Network

The Claims Administrator arranges for health care providers to participate in a Network. Network providers are independent

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practitioners. They are not our employees or employees of the Claims Administrator. It is your responsibility to select your provider.

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

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

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

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

Care Coordination℠

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

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

Designated Facilities and Other Providers

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

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

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

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Health Services from Non-Network Providers Paid as Network Benefits

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

Limitations on Selection of Providers

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

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

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

Non-Network Benefits

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

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

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

Notification Requirement

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

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

Care Coordination℠

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

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.

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

If you are confined in a non-Network Hospital after you receive Emergency Health Services, the Claims Administrator must be notified within one business day or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

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Section 4: When Coverage Begins

This section includes information about:

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

How to Enroll

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

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

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

If You Are Eligible for Medicare

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

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

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Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Eligible Person	Eligible Person usually refers to an employee of ours who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Participant. For a complete definition of Eligible Person and Participant, see (Section 10: Glossary of Defined Terms). Except as we have described in (Section 4: When Coverage Begins), Eligible Persons may not enroll.	We determine who is eligible to enroll under the Plan.
Dependent	Dependent generally refers to the Participant's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see (Section 10: Glossary of Defined Terms). Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan. Except as we have described in (Section 4: When Coverage Begins), Dependents may not enroll.	We determine who qualifies as a Dependent.

When to Enroll and When Coverage Begins

When to Enroll	Who Can Enroll	Begin Date
Initial Enrollment Period The Initial Enrollment Period is the first period of time when Eligible Persons can enroll.	Eligible Persons may enroll themselves and their Dependents.	Coverage begins on the date identified by the Plan Administrator, if the Plan Administrator receives the completed enrollment form and any required contribution for coverage within 30 days of the date the Eligible Person becomes eligible to enroll.
Open Enrollment Period The Plan Administrator determines the Open Enrollment Period.	Eligible Persons may enroll themselves and their Dependents.	Coverage begins on the date identified by the Plan Administrator if the Plan Administrator receives the completed enrollment form and any required contribution within the time frames specified by the Plan Administrator at Open Enrollment.
New Eligible Persons A New Eligible Person is a New Hire.	New Eligible Persons may enroll themselves and their Dependents.	Coverage begins on the first day of the month following the completion of a 30 day waiting period if the Plan Administrator receives the properly completed enrollment form and any required contribution for coverage within 30 days of the date the new Eligible Person becomes eligible to enroll.
Adding New Dependents	Participants may enroll Dependents who join their family because of any of the following events: • Birth. • Legal adoption. • Placement for adoption.	Coverage begins on the date of the event if the Plan Administrator receives the completed enrollment form and any required contribution for coverage within 30 days of the event that makes the new Dependent eligible. Coverage resulting from a marriage or

When to Enroll	Who Can Enroll	Begin Date
	• Marriage. • Legal guardianship. • Court or administrative order. • Registering a Domestic Partner.	registering a Domestic Partner begins on the first of the next month if the Plan Administrator receives the completed enrollment form and any required contribution for coverage within 30 days of the event that makes the new Dependent eligible.

Special Enrollment Period

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

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

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

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- Registering a Domestic Partner.

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

- The Eligible Person previously declined coverage under the Plan, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP (you must notify the Plan Administrator within 60 days of determination of subsidy eligibility);
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and

Event Takes Place (for example, a birth, marriage or determination of eligibility for state subsidy). Unless otherwise noted under the "Who Can Enroll" column, coverage begins on the date of the event if the Plan Administrator receives the completed enrollment form and any required contribution within 30 days of the event.

Coverage resulting from a marriage or registering a Domestic Partner begins on the first of the next month if the Plan Administrator receives the completed enrollment form and any required contribution for coverage within 30 days of the event that makes the new Dependent eligible.

Missed Initial Enrollment Period or Open Enrollment Period. Unless otherwise noted under the "Who Can Enroll" column, coverage begins on the day immediately following the day coverage under the prior plan ends if the Plan Administrator receives the completed enrollment form and any required contribution within 30 days of the date coverage under the prior plan ended.

When to Enroll	Who Can Enroll	Begin Date
	• Coverage under the prior plan ended because of any of the following: — Loss of eligibility (including, without limitation, legal separation, divorce or death). — The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer. — In the case of COBRA continuation coverage, the coverage ended. — The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available. — The Plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent. — An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits under the elected health care option if the plan, the Eligible Person or Dependent is currently enrolled in is not one offered by the Employer. — Termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must notify the Plan Administrator within 60 days of termination).	

Section 5: How to File a Claim

This section provides you with information about:

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

If You Receive Covered Health Services from a Network Provider

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

Filing a Claim for Benefits

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us through the Claims Administrator. You must file the claim in a format that contains all of the information required, as described below.

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

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

Required Information

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

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

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Payment of Benefits

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

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

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

Benefit Determinations

Post-Service Claims

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

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

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

Pre-Service Requests for Benefits

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

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Urgent Requests for Benefits that Require Immediate Action

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

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

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

You will be notified of a determination no later than 24 hours after:

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

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

Concurrent Care Claims

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

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

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Section 6: Questions, Complaints and Appeals

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

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

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

What to Do First

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

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

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

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

How to Appeal a Claim Decision

If you 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. Your request should include:

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

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

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Appeal Process

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

In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, United HealthCare Services, Inc. will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

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

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

For appeals of pre-service requests for Benefits as defined in (Section 5: How to File a Claim), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. The second level appeal will be conducted and you will be notified by us of the decision within 15 days from receipt of a request for review of the first level appeal decision. We may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

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

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

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

The Plan Administrator has the exclusive right to interpret and administer the Plan, and these decisions are conclusive and binding.

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

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Urgent Appeals that Require Immediate Action

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

- The appeal does not need to be submitted in writing.
- You or your Physician should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt by the Claims Administrator of your request for review of the determination taking into account the seriousness of your condition.

For urgent requests for Benefits appeals, we have delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Plan.

External Review Program

If, after exhausting your internal appeals, you are not satisfied with the final determination, you may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on:

- Clinical reasons;
- The exclusions for Experimental or Investigational Services or Unproven Services; or
- As otherwise required by applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure or the denial

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of payment for a service or procedure. The process is available at no charge to you after exhausting the appeals process identified above and you receive a decision that is unfavorable, or if United HealthCare Services, Inc. fails to respond to your appeal within the time lines stated below.

You may request an independent review of the adverse benefit determination. Neither you nor United HealthCare Services, Inc. will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision.

All requests for an independent review must be made within four (4) months of the date you receive the adverse benefit determination. You, your treating Physician or an authorized designated representative may request an independent review by contacting the toll-free number on your ID card or by sending a written request to the address on your ID card.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a Covered Health Service under the Plan. The Independent Review Organization (IRO) has been contracted by United HealthCare Services, Inc. and has no material affiliation or interest with United HealthCare Services, Inc. or Franklin County Board of Commissioners. United HealthCare Services, Inc. will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.

Within applicable timeframes of United HealthCare Services, Inc.'s receipt of a request for independent review, the request will be forwarded to the IRO, together with

- All relevant medical records;

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- All other documents relied upon by United HealthCare Services, Inc. in making a decision on the case; and
- All other information or evidence that you or your Physician has already submitted to United HealthCare Services, Inc.

If there is any information or evidence you or your Physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an independent review, and United HealthCare Services, Inc. will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide you and United HealthCare Services, Inc. with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide Benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the service or procedure.

You may contact United HealthCare Services, Inc. at the toll-free number on your ID card for more information regarding your external appeal rights and the independent review process.

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Section 7: Coordination of Benefits

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; or
- 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 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.

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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; or
  - 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 legally separated parents and if there is no court decree stating that one 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

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— 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; and
- 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 Plan year, the benefit reserve returns to zero. A new benefit reserve is created for each Plan year.

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

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

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; and
- 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 Plan and other plans. The Plan Administrator may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

The Plan Administrator does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give United HealthCare Services, Inc. any facts needed to apply those rules and determine benefits payable. If you do not provide United HealthCare Services, Inc. the information needed 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 United HealthCare Services, Inc. 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, United HealthCare Services, Inc. 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

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

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

General Information about When Coverage Ends

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

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

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

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

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Events Ending Your Coverage

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

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

Other Events Ending Your Coverage

When any of the following happens, we will provide prior written notice to the Participant that coverage will end on the date the Plan Administrator identifies in the notice:

Ending Event	What Happens
Fraud, Misrepresentation or False Information	You commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include false information relating to another person's eligibility or status as a Dependent. We have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.
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 Enrolled Dependent child who is incapacitated because of an intellectual/developmental disability, mental or physical handicap will not end just because the child has reached a certain age. We will extend coverage for that child beyond the limiting age if all three of the following are true regarding the Enrolled Dependent child:

- Child is not able to be self-supporting because of an intellectual/developmental disability, mental or physical handicap;
- Child depends mainly on the Participant for support and maintenance;
- Disability began prior to the Enrolled Dependent child reaching the limiting age.

Coverage will continue as long as the Enrolled Dependent continues to meet the above requirements 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 30 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.

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

If you do not provide proof of the child's incapacity and dependency within 30 days of the Claims Administrator's request as described above, coverage for that child will end.

Extended Coverage for Full-time Students

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

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

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

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

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

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

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

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 your right to continue coverage.

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

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

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

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

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

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

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

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

A. Termination of the Participant's employment (for reasons other than the Participant's gross misconduct).
B. Reduction in the Participant's hours of employment.

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

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

Notification Requirements for Qualifying Event

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

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

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

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

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

Notification Requirements for Disability Determination or Change in Disability Status

The Participant or other Qualified Beneficiary must notify the Plan Administrator as described under "Terminating Events for Continuation Coverage under Federal Law (COBRA)," subsection A. below.

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

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

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

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

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

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

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

Terminating Events for Continuation Coverage under Federal Law (COBRA)

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

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

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

   — Notice of such disability must be provided within the latest of 60 days after:
      - The determination of the disability; or
      - The date of the qualifying event; or
      - The date the Qualified Beneficiary would lose coverage under the Plan; and
      - In no event later than the end of the first eighteen months.
   — The Qualified Beneficiary must agree to pay any increase in the required premium for the additional eleven months.
   — If the Qualified Beneficiary who is entitled to the eleven months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional eleven months of continuation coverage.

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

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

C. With respect to Qualified Beneficiaries, and to the extent that the Participant was entitled to Medicare prior to the qualifying event:

   — Eighteen months from the date of the Participant's termination of employment or work hours being reduced; or

   — Thirty-six months from the date of the Participant's Medicare entitlement, if a second qualifying event (that was due to either the Participant's termination of employment or the Participant's work hours being reduced) occurs prior to the expiration of the eighteen months.

D. With respect to Qualified Beneficiaries, and to the extent that the Participant became entitled to Medicare subsequent to the qualifying event:

   — Thirty-six months from the date of the Participant's termination from employment or work hours being reduced (first qualifying event) if:

      ♦ The Participant's Medicare entitlement occurs within the eighteen month continuation period; and

      ♦ Absent the first qualifying event, the Medicare entitlement would have resulted in a loss of coverage for the Qualified Beneficiary under the group health plan.

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

F. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

G. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event G). If the Qualified Beneficiary was entitled to continuation because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event G) and the retired Participant dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for thirty-six months from the date of the Participant's death.

H. The date the entire Plan ends.

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

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Military Leave Policy

A Participant who is absent from employment by reason of service in the Uniformed Services may continue coverage under the Plan for the Participant and the Participant's Enrolled Dependents in accordance with the policy set forth in the Participant's employee handbook. The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of Public Health Service, and any other category of persons designated by the President or an act of congress in time of war or national emergency.

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If qualified to continue coverage pursuant to the employee handbook policies, Participants must notify the Plan Administrator in advance and provide payment of any required contribution for coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period of time less than 31 days, the Participant may not be required to pay more than the regular contribution amount, if any, for continuation of coverage.

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Section 9: General Legal Provisions

This section provides you with information about:
- General legal provisions concerning the Plan.

Plan Document

This Summary Plan Description (SPD) represents an overview of your Benefits. In the event there is a discrepancy between the SPD and the official plan document, the plan document will govern.

Your Relationship with the Claims Administrator and Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how the Claims Administrator interacts with the Plan Sponsor's benefit Plan and how it may affect you. The Claims Administrator helps administer the Plan Sponsor's benefit plan in which you are enrolled. The Claims Administrator does not provide medical services or make treatment decisions. This means:

- The Plan Sponsor and the Claims Administrator do not decide what care you need or will receive. You and your Physician make those decisions.
- The Claims Administrator communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD).
- The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

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We and the Claims Administrator may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We and the Claims Administrator will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We and the Claims Administrator will use de-identified data for commercial purposes including research.

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, nor are the Claims Administrator and any of its employees agents or employees of Network providers.

We and the Claims Administrator do not provide health care services or supplies, nor do we practice medicine. Instead, we and the Claims Administrator arranges for health care providers to participate in a Network to pay Benefits. Network providers are independent practitioners who run their own offices and facilities. The Claims Administrator's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. We and the Claims Administrator do not have any other relationship with

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

Network providers such as principal-agent or joint venture. We and the Claims Administrator are not liable for any act or omission of any provider.

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

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

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

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments and any Annual Deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- 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.

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- You must decide with your provider what care you should receive.

Incentives to Providers

Network providers may be provided financial incentives by the Claims Administrator to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost effectiveness.
- A practice called capitation which is when 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.

If you have questions regarding financial incentives you may contact the telephone number on your ID card. You can ask 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. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain

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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.

Rebates and Other Payments

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

Interpretation of Benefits

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

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

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

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

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Administrative Services

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

Amendments to the Plan

Although we expect to continue the Plan indefinitely, we reserve the right, to discontinue, alter or modify the Plan in while 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.

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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. 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 or the Claims Administrator have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Participant's enrollment form. We and the Claims Administrator agree that such information and records will be considered confidential.
- We and the Claims Administrator have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Plan, we, the Claims Administrator, and our related entities may use and transfer the information gathered under the Plan 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 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 Physician of our choice examine you at our expense.

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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.

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Subrogation

The right to subrogation means 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 Benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is considered responsible. Subrogation applies when the Plan has paid on your behalf Benefits for a Sickness or Injury for which a third party is considered responsible, e.g. an insurance carrier if you are involved in an auto accident.

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

Right to Reimbursement

The right to reimbursement means that if a third party causes a Sickness or Injury for which you receive a settlement, judgment, or other recovery 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.

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Third Parties

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity who caused the Sickness, Injury or damages.
- The Plan Sponsor in workers' compensation cases.
- Any person or entity who is or may be obligated to provide you with benefits or payments under:
  - underinsured or uninsured motorist insurance.
  - medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise.
  - workers' compensation coverage.
  - any other insurance carrier or third party administrator.

Subrogation and Reimbursement Provisions

As a Covered Person, you agree to the following:

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, our 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 you recover from a third party.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- 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 shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- You will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - Complying with the terms of this section;
  - Providing any relevant information requested;
  - Signing and/or delivering documents at its request;
  - 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;
  - Responding to requests for information about any accident or injuries;

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— Appearing at medical examinations and legal proceedings, such as depositions or hearings; and

— Obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.

- If you receive payment as part of a settlement or judgment from any third party as a result of a Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a Sickness or Injury caused by a third party.
- The Plan's rights will not be reduced due to your own negligence.
- The Plan may, at its option, take necessary and appropriate action to assert its rights under this section, including filing suit in your name, which does not obligate it in any way to pay you part of any recovery the Plan might obtain.
- 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.

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

- In 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.
- Your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.
- If a third party causes you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Covered Person.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

Limitation of Action

If you want to bring a legal action against us or the Claims Administrator you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted, or you lose any rights to bring such an action against us or the Claims Administrator.

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

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Section 10: Glossary of Defined Terms

This section:

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

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

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

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

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

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

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

Cancer Resource Services - the program made available by the Plan Sponsor to Participants. The Cancer Resource Services program provides information to Participants or their Enrolled Dependents with cancer and offers access to additional cancer centers for the treatment of cancer.

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

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

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

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

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

A Covered Health Service is a health care service or supply described in (Section 1: What's Covered--Benefits) as a Covered

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Health Service, which is not excluded under (Section 2: What's Not Covered--Exclusions).

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

Custodial Care - services that:

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

Dependent - the Participant's legal spouse or a dependent child of the Participant or the Participant's spouse. All references to the spouse of a Participant shall include a Domestic Partner. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Participant or the Participant's spouse.

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

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

- A Dependent includes any dependent child under 26 years of age.
- A Dependent includes any unmarried dependent child who is 26 years of age or older, but less than 28 years of age if satisfactory evidence is provided and the following conditions are met:
  - The Dependent is not eligible for coverage through an employer.
  - The Dependent is not eligible for Medicaid or Medicare.
  - The Dependent is residing in the state of Ohio; or the Dependent is a full time student residing outside of the state of Ohio.
- A Dependent who is incapacitated because of an intellectual/developmental disability, mental or physical handicap, if the following are true:
  - Child is not able to be self-supporting because of an intellectual/developmental disability, mental or physical handicap;
  - Child depends mainly on the Participant for support and maintenance;
  - Disability began prior to the child reaching the limiting age.

  Periodic proof of the child's continued incapacity and dependency will be required.

- A dependent also includes the Dependent of a Participant's Domestic Partner. The Domestic Partner must be enrolled in order to enroll the Dependent of a Participant's Domestic Partner.

- A dependent also includes the child of an enrolled dependent child, i.e. grandchild of the employee. The dependent child of the employee must be enrolled in order to enroll a grandchild.

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

The Participant 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.

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

Domestic Partner - a person of the opposite or same sex with whom the Participant has established a Domestic Partnership.

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

- They are not related by blood or a degree of closeness that would prohibit marriage in the state in which they reside.
- They must not be currently married to, separated from, or a Domestic Partner of, another person under either statutory or common law.
- They must share a permanent residence.
- They must be at least eighteen (18) years of age and mentally competent to consent to contract.
- They must have been in a relationship of domestic partnership for at least the past six (6) months and intend to remain in the relationship indefinitely.

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- They share responsibility for each other's common welfare.
- They must be currently and for at least the past six (6) months financially interdependent upon each other. Financial interdependency must be supported by three of the following:
    - Joint ownership of real estate property or joint tenancy on a residential lease
    - Joint ownership of an automobile.
    - Joint checking, bank or investment account.
    - Joint credit account (e.g. credit card, loan)
    - A retirement plan, will or life insurance policy designating the other as primary beneficiary
    - A durable power of attorney granting power to the other

The Participant and Domestic Partner must jointly sign an Affidavit of Domestic Partnership and furnish documents to support financial interdependency for at least the past six(6) months.

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

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

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

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

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

For Non-Network Benefits, Eligible Expenses are determined by either:

- Available data resources of competitive fees in that geographic area.
- Fee(s) that are negotiated with the provider.
- 50% of the billed charge.
- A fee schedule that the Claims Administrator develops.

Eligible Person - a regular full-time employee of the Plan Sponsor who is scheduled to work at his or her job at least 30 hours per week.

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

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

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

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 or devices that, at the time a determination is made regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

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

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

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

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

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

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.

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

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

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

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

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

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

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with the Claims Administrator's affiliate to participate in the Claims Administrator's Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with them through common ownership or control with the Claims Administrator or with its ultimate corporate parent, including direct and indirect subsidiaries.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Plan - Choice Plus for Franklin County Board of Commissioners Health Benefit Plan.

Plan Administrator - is Franklin County Board of Commissioners or its designee.

Plan Sponsor - Franklin County Board of Commissioners. References to "we", "us", and "our" throughout the SPD refer to the Plan Sponsor.

Pregnancy - includes all of the following:

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

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

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

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

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

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

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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.

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

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

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

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

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Urgent Care Center - a facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

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Riders, Amendments, Notices

Attachment I

Attachment II

Attachment III

Attachment I

Women's Health and Cancer Rights Act of 1998

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

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

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

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

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

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

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

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

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Attachment II

Summary Plan Description

Name of Plan: Franklin County Board of Commissioner Health Plan

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

Franklin County Board of Commissioners
373 South High Street
25th Floor
Columbus, OH 43215-6314
(614) 525-5750

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibilites with respect to the Plan.

Employer Identification Number (EIN): 31-6400067

IRS Plan Number: 501

Effective Date of Plan: April 1, 2012

Type of Plan: Group health care coverage plan

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Name, Business address, and Business Telephone Number of Plan Administrator:

Franklin County Board of Commissioners
373 South High Street
25th Floor
Columbus, OH 43215-6314
(614) 525-5750

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

United Healthcare Services, Inc.
Attn: Claims
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 Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

To Request a Certificate of Creditable Coverage, contact:

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

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

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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 Sponsor also has selected a provider network established by United HealthCare Insurance Company. The named fiduciary of Plan is Franklin County Board of Commissioners, the Plan Sponsor.

Person designated as agent for service of legal process: Service of process may also be made upon the Plan Administrator.

Source of contributions under the Plan: There are no contributions to the Plan. All Benefits under the Plan are paid from the general assets of the Plan Sponsor. Any required employee contributions are used to partially reimburse the Plan Sponsor for Benefits under the Plan.

Method of calculating the amount of contribution: Employee-required contributions to the Plan Sponsor are the employee's share of costs as determined by Plan Sponsor. From time to time the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

Date of the end of the year for purposes of maintaining Plan's fiscal records: The 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.

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Although the Plan Sponsor currently intends to continue the Benefits provided by this Plan, the 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 conditions, in whole or in part, shall be made solely in a written amendment (in the case of a change or amendment) or in a written resolution (in the case of 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.

Benefits under the Plan are furnished in accordance with the Plan Description issued by the Plan Sponsor, including this Summary Plan Description.

Participants' 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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Attachment III

HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

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

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

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

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obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

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