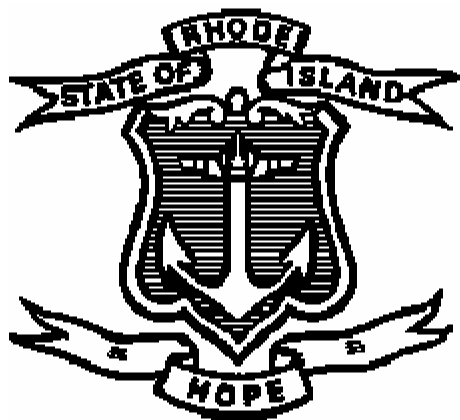
Summary Plan Document
Early Retirees PPO Plan



Group Number: 707837
Effective Date: May 1, 2005

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Introduction

We are pleased to provide you with this Summary Plan Document (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.

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.

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

Certain capitalized words have special meanings. We have defined these words in Section 10: Glossary of Defined Terms. You can refer to Section 10 as you read this document to have a clearer understanding of your SPD.

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

Your Contribution to the Benefit Costs

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

Customer Service and Claims Submittal

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

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

Prior Notification: As shown on your ID card.

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

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

Claims Submittal Address:

United HealthCare Insurance Company

Attn: Claims

P. O. Box 740800

Atlanta, Georgia 30374-0800

Requests for Review of Denied Claims and Notice of Complaints:

Name and Address For Submitting Requests:

United HealthCare Insurance Company

P. O. Box 30573

Salt Lake City, Utah 84130-0573

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Section 1: What's Covered--Benefits

This section provides you with information about:

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

Accessing Benefits

You can choose to receive either Network Benefits or Non-Network Benefits. To obtain Network Benefits you must see a Network Physician or other Network provider.

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

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.

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

Copayment

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

Eligible Expenses

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

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

For Network Benefits, you are not responsible for any difference between the Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses.

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

Pre-Authorization

Network Providers shall be responsible for complying with pre-authorization requirements, if any, set forth in the contract between the Network Providers and the Claims Administrator for the services listed below.

When utilizing a Non-Network Provider, it is recommended that you obtain pre-authorization for the services listed below.

Failure to obtain pre-authorization may result in a denial if the services are determined by a Physician not to be medically necessary or received in an inappropriate setting.

Pre-Authorization List:

Inpatient Substance Abuse
Home Health Care/Home Infusion Therapy
Hospice Care
Hospital Inpatient Stay
Transplantation Services
Private Duty Nursing
Care in a Skilled Nursing Facility

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.

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

Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services before you are eligible to receive Benefits.	***Network*** No Annual Deductible. ***Non-Network*** No Annual Deductible.
Out-of-Pocket Maximum	The maximum you pay, out of your pocket, in a calendar year for Copayments. For a complete definition of Out-of-Pocket Maximum, see Section 10: Glossary of Defined Terms.	***Network*** No Out-of-Pocket Maximum. ***Non-Network*** $3,000 per Covered Person per calendar year, not to exceed $9,000 for all Covered Persons in a family.
Maximum Plan Benefit	The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Plan.	***Network*** No Maximum Plan Benefit. ***Non-Network*** No Maximum Plan Benefit.

Benefit Information

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
1. Ambulance Services ***Ground Ambulance*** Local professional or municipal ground ambulance services are covered when it is medically necessary to use these services, rather than any other form of transportation, to the following destinations: (a) to the closest available Hospital for an inpatient admission; (b) from a Hospital to home or to a Skilled Nursing Facility after being discharged as an inpatient; (c) to the closest available Hospital emergency room immediately in an emergency; OR (d) to and from a Hospital for medically necessary services not available in the facility where you are an inpatient. Our allowance for the ground ambulance includes attendant services, drugs, supplies and cardiac monitoring.	***Network***	*Ground Transportation:* No Copayment *Air and Water Transportation:* No Copayment up to a $3,000 Maximum Benefit per occurrence	No
	Non-Network	*Ground Transportation:* No Copayment *Air and Water Transportation:* No Copayment up to a $3,000 Maximum Benefit per occurrence	No

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?

Air/Water Ambulance

Medically necessary air and water ambulance services are covered up to the maximum amount of $3,000 per occurrence.

Air ambulance service involves transportation by means of a helicopter or fixed wing aircraft. The aircraft must be a certified ambulance and the crew, maintenance support crew and aircraft must meet the certification requirements and hold a certificate for air ambulance operators under Part 135 of the Federal Aviation Administration (FAA) regulations.

Water ambulance involves transportation by means of a boat. The boat must be specially designed and equipped for transporting the sick or injured and it must also have such other safety and lifesaving equipment as is required by state or local authorities.

Use of an air/water ambulance is medically necessary when the time needed to transport a patient by land, or the instability of transportation by land, poses a threat to the patient's condition or survival or the proper equipment required to treat the patient is not available on a land ambulance.

The patient must be transported for treatment to the nearest appropriate facility that is capable of providing a level of care for the patient's illness and that has available the type of Physician needed to treat the patient's condition.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
This Plan will only cover air and water ambulance services originating and terminating in the United States and its territories. Our allowance for the air/water ambulance includes attendant services, drugs, supplies and cardiac monitoring.		

Related Exclusions

Air/water ambulance is NOT covered for transport to a facility that is not an acute care Hospital, such as a Physician's office, nursing facility, or the patient's home.

This Plan does NOT provide coverage for transport from cruise ships when not in United States waters.

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
2. Cancer Resource Services Cancer Resource Services is a voluntary program in which you will receive assistance in obtaining care that is planned, coordinated and provided by a team of experts who specialize in your specific cancer. 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.	***Network*** Cancer Resource Services must be called.	No Copayment	No
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).	***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.

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?

3. Cancer Therapies - Investigational

Benefits for the costs of investigational treatment and associated protocol related patient care for investigative cancer therapies if all of the following requirements are met:

- The treatment is being conducted in a Phase II, III or IV cancer clinical trial.
- The clinical trial has been approved by one of the following:
  1. National Institutes of Health in cooperation with the National Cancer Institute, community clinical oncology programs.
  2. The federal Food and Drug Administration for the purpose of an investigational new drug application.
  3. The U.S. Department of Veterans Affairs.
  4. A qualified non-governmental research entity as identified in the National Cancer Institute's cancer center support grants.
- The proposed therapy must have been reviewed and approved by a qualified institutional review board.
- The facility and personnel providing the treatment must be capable of providing the treatment by virtue of their experience, training and volume of patients treated to maintain expertise.
- The patients receiving the investigational treatment must meet all protocol requirements.

Network

Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Diagnostic and Therapeutic Services.

Non-Network

Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Diagnostic and Therapeutic Services.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?

- There must be no clearly superior non-investigational approach.
- The available clinical or preclinical data must provide a reasonable expectation that the treatment will be at least as worthwhile as the non-investigational alternative.

Benefits are not provided for that part of a Phase II clinical trial that is ordinarily paid for by one of the following:

- A national agency such as the National Cancer Institute, U.S. Department of Veterans Affairs or the Department of Defense.
- Commercial organizations such as biotechnical, pharmaceutical or medical device industry, either within or without the state.
- Any other governmental or non-governmental source that customarily pays for all or part of a Phase II trial.

Coverage for Clinical Trials at a Cancer Resource Services designated facility is not covered as part of this benefit.

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
4. Chiropractic Treatment Benefits for Chiropractic Treatment when provided by a Chiropractic Treatment provider in the provider's office. 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 Chiropractic Treatment, regardless of the place of service, is limited to 12 visits per calendar year. This plan does not cover X-rays read by a Chiropractic physician.	***Network***	$10 per visit	No
	Non-Network	20%	Yes
5. Contraceptive Devices Benefits for Contraceptive Devices for all F.D.A. approved devices requiring a prescription including: • Surgical implantation and removal of I.U.D.'s and contraceptive implants such as, but not limited to, Norplant pellets. • Diaphragms supplied in a Physician's office are covered as a medical supply and are subject to the allowances for durable medical equipment. Injectable contraceptive drugs purchased at a pharmacy or administered by a Physician in a Physician's office.	***Network***	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Diagnostic, injections received in a physician's office, durable medical equipment, and Therapeutic Services.	
	Non-Network	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Diagnostic, injections received in a physician's office, durable medical equipment, and Therapeutic Services.	

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
6. Dental Services - Accident only Dental services when all of the following are true: • Treatment is necessary because of accidental damage. • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D." • The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident.	***Network***	No Copayment	No
Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was: • A virgin or unrestored tooth, or • A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech. Only the following services are covered: • Extraction of teeth needed to avoid infection of teeth damaged in the injury; • Suturing and suture removal; • Reimplanting and stabilization of dislodged teeth; • Repositioning and stabilization for partly dislodged teeth; and • Medication received from the provider.	***Non-Network***	Same as Network	Same as Network

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
Note that suture removal performed when the original emergency dental services were received is covered as part of our allowance for the original dental emergency treatment. This plan only covers a separate charge for suture removal if the suturing and suture removal are performed at different locations (i.e., sutures at emergency room and suture removal at physician's office). 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.			
7. Diabetes Services Services and supplies for the diagnosis or treatment of insulin treated diabetes, non-insulin treated diabetes and gestational diabetes, including: • Insulin pumps and insulin pump supplies. • Insulin infusion devices. • Therapeutic/molded shoes for the prevention of amputation. Limited to 2 pair of shoes or 4 individual shoes per calendar year. Includes inserts up to 2 pairs of inserts per pair of shoes or 2 inserts if only one shoe is dispensed. Additional inserts for depth shoes are covered up to 3 pairs of inserts per pair of shoes or three inserts if only one shoe is dispensed. • Syringes and Diabetic test strips.	***Network***	***Inpatient*** No Copayment for equipment and supplies ***Outpatient*** 20% for equipment and supplies	No

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
• Blood glucose monitors, including for those individuals who are legally blind. • Injection aids, cartridges for the legally blind and oral agents for controlling blood sugar. • Supplies and equipment approved by the FDA for the purposes for which they have been prescribed. Diabetes outpatient self-management training and education, including medical nutrition therapy, when provided by a certified diabetes health care provider. If more than one piece of Durable Medical Equipment for the treatment of diabetes can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment.	***Non-Network***	$10 per visit for diabetes self-management education 20%	 Yes

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
8. Diagnostic Services	***Network***	***For lab and radiology/ X-ray:***	
Diagnostic Services Covered Health Services received on an inpatient, outpatient, or in a physician's office including:		No Copayment	No
• Lab and radiology/X-ray, including Imaging Electrocardiograms (EKGs), Electroencephalograms (EEGs), ultrasongarphy (ultrasound); audiometric hearing and speech tests, blood tests and typing, urinalysis, and nose/throat cultures.		***For mammography testing:*** No Copayment	No
• Mammography testing and pap smears in accordance with current American Cancer Society guidelines. Additionally, two mammograms will be covered per year when recommended by a physician for women who have been treated for breast cancer within the last five (5) years or are at high risk of developing breast cancer due to genetic predisposition (BRCA gene mutation or multiple first degree relatives) or high risk lesion on prior biopsy (lobular carcinoma in situ) or atypical ductal hyperplasia.	***Non-Network***	20%	Yes
• Prostate and colorectal examinations and laboratory tests in accordance with current American Cancer Society guidelines			
• Computerized Axial Tomography CT scans, Pet scans, MRI, and nuclear medicine.			
• Magnetic Resonance Angrography (MRA) of head and neck when you are suspected of having the following:			

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?

- Steno-occlusive disease of the mid or large size intracranial arteries;
- Cerebral aneurysms;
- Intracranial vascular malformation;
- Cerebral venous sinus compression or thrombosis;
- Pulsatile tinnitus;
- Carotid stenosis or occlusion;
- Cervicocranial arterial dissection.

This plan covers doctor services for the initial reading or initial interpretation of the diagnostic machine tests and x-rays listed above when billed by a doctor. This plan covers the pathologist's initial reading and interpretation of Pap Smear results.

Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.

Note that pathological examinations performed in a hospital are only covered by this plan when billed by the hospital.

Outpatient Therapeutic Treatments

Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, radiation and other treatments not listed above.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?

Outpatient Radiation Therapy: This plan covers hospital and doctor services for outpatient radiation therapy. Radiation physics, dosimetry services, treatment devices, and hospital services are included in radiation treatment planning and therapy and are covered as part of our allowance for radiation therapy.

Outpatient Chemotherapy: This plan covers the doctor's administration fee and associated hospital supplies for infused anti-neoplastic prescription drugs used for the treatment of cancer.

Outpatient hemodialysis must be received in a hospital's outpatient unit or in an approved hemodialysis facility.

This Plan covers the following services for treatment of hemophilia:

- Yearly evaluation;
- Medically necessary visits;
- Hemophilia outpatient physical therapy up to 56 treatments per calendar year;
- Clotting factor drugs; AND
- Supplies.
- When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services.*

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
9. Durable Medical Equipment	***Network***	***Inpatient*** No Copayment	No
		Outpatient 20%	No
	Non-Network	***Inpatient*** 20%	Yes
		Outpatient 20%	No

9. 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).

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?

- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part, braces to treat curvature of the spine, and cranial orthosis or helmet and Hi-Knee-Ankle-Foot-Orthosis (HKAFO) are considered Durable Medical Equipment and are Covered Health Services. Other braces that straighten or change the shape of a body part, dental braces, and shoe and foot orthotics are excluded from coverage.
- Essential accessories such as hoses, tubes, and mouthpieces for necessary durable medical equipment ONLY if you own the equipment (these accessories are included as part of the rental allowance for rental equipment).
- 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).
- 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.
- Contact lenses or glasses following cataract surgery.
- Diaphragms supplied in a Physician's office.

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
• Custom ordered compression stockings are only covered when prescribed by a physician. Limit is (4) pairs of stockings, up to (8) units in a calendar year. "Over the counter" stockings are not covered, nor stockings for prosthetics. • The rental of a hospital grade electric breast pump for NICU babies separated at least 24 hours from the mother when ordered by the child's physician. The Claims Administrator will decide if the equipment should be purchased or rented. You must purchase or rent the Durable Medical Equipment from the vendor the Claims Administrator identifies. Repairs to rental equipment are an expense of the vendor; repairs to equipment you own are your liability. Note: Regular batteries or specialized batteries necessary for equipment are NOT covered.			
10. Early Intervention Services Benefits are payable for preventive and primary services for a Dependent child younger than three years of age who is certified by the department of human services as eligible for early intervention services. Covered Health Services include, but are not limited to, the following:	***Network***	No Copayment	No

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
• Occupational therapy. • Speech therapy. • Physical therapy. • Evaluation. • Case Management. • Service plan development and review. • Nursing care. • Nutritional services. • Psychological counseling. • Assistive technology services and devices consistent with early intervention programs approved by the Department of Health. The maximum amount we will pay for any combination of Network and Non-Network Benefits during a calendar year is $5,000 per dependent child. Early intervention services must be given by a licensed provider designated by the Department of Human Services as an "early intervention provider" and who works in early intervention programs approved by the Department of Health.	***Non-Network***	No Copayment	No

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
11. Emergency Health Services Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility. If you have an accident or medical emergency that requires emergency room services, and your first visit to the emergency room occurs within twenty-four (24) hours of the accident or onset of symptoms, this plan covers the hospital or emergency room services and the doctor's services. Bandages, crutches, canes, collars and other supplies incidental to your treatment in the emergency room are covered as part of our allowance for the emergency room services.	***Network***	$25 per visit Copayment waived if admitted to Hospital within 24 hours.	No
If you receive treatment in an emergency room for a non-emergency, this plan does NOT cover the hospital or other facility's services. Follow-up visits to the emergency room are not covered. You will find more information about Benefits for Emergency Health Services in (Section 3: Description of Network and Non-Network Benefits).	***Non-Network***	Same as Network	No

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
12. Podiatry Services This plan covers office visits to the Podiatrist. The treatment of corns, or calluses, bunions (except capsular or bone surgery), the cutting and trimming of toenails, foot care for flat feet, fallen arches and chronic foot strain or symptomatic foot complaints (except when surgery is performed), and routine foot care are not covered.	***Network***	$10 per visit	No
Cutting of corns and calluses, trimming of nails, and debridement of nails are covered for diabetics with peripheral neuropathy.	***Non-Network***	20%	Yes
13. Hearing Aids (Effective 01/01/07) Coverage for a Hearing Aid must be ordered by a Physician. Coverage is provided for one thousand five hundred dollars ($1,500) per individual hearing aid, per ear every three (3) years for anyone under the age of nineteen (19) years, and for seven hundred dollars ($700) per individual hearing aid, per ear, every three (3) years for anyone of the age of nineteen (19) years and older.	***Network***	See Maximum Limits	No
"Hearing Aid" - Any non-experimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, but excluding batteries, cords, and other assistive listening devices, including, but not limited to FM systems.	***Non-Network***	20%	Yes

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
14. Home Health Care Services received from a Home Health Agency that are medically necessary and are as follows: • Ordered by a Physician. • The program is formulated and supervised by the Participant's Physician; and • Provided by or overseen by a registered nurse or provided by a home health aid in your home.	When part of a coordinated home care program: ***Network***	No Copayment	No
Benefits are available only when the Home Health Agency services are provided on a full-time, part-time, intermittent schedule and when skilled care is required. Preauthorization is recommended.	***Non-Network***	20%	Yes
Benefits are available for the following services: • Physical/Occupational therapy: must be received from a licensed physical or occupational therapist and through a pre-authorized home care program. • Speech therapy. • Respiratory services. • Medical social work. • Nutritional counseling. • Prescription drugs and medications.	When not part of a coordinated home care program: ***Network***	20%	No

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?

• Medical and surgical supplies.
• Minor equipment such as commodes and walkers.
• Laboratory and X-ray services, E.E.G. and E.K.G. evaluations.
• Home infusion therapies. The following services are covered:
  • nursing visits billed by the agency;
  • total enteral nutrition;
  • hydration therapy; antibiotic therapy;
  • enteral nutrition;
  • human growth hormone;
  • pentamidine;
  • immunoglobulin;
  • chelation;
  • drugs relating directly to the home infusion therapy;
  • solutions;
  • related equipment;
  • supplies; and
  • the services of the home infusion nurse.
	Non-Network	20%	No

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:			

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?

- 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.

A service will not be determined to be "skilled" simply because there is not an available caregiver. Please contact the Claims Administrator for more information regarding guidelines for home health care. You can contact the Claims Administrator at the telephone number on your ID card.

Note: This plan does NOT cover radiation treatment services received in your home. This plan covers oral and injectable anti-neoplastic prescription drugs when they have been approved by us and are used solely for the purpose of cancer treatment.

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
15. Hospice Care	***Network***	No Copayment	No
	Non-Network	20%	Yes

15. 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 an approved hospice agency.

If you have a terminal illness and you agree with your doctor not to continue with a curative treatment program, this plan covers some hospice care services provided by an approved hospice care program, as set forth in this section.

This plan covers the following services and supplies received through an approved hospice care program.

- services of a hospice coordinator billed by the hospice care program;
- services of a visiting nurse when billed by a visiting nurse agency; AND
- services of a home health aide.

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
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. Preauthorization is recommended for Non-Network care.			

16. Hospital - Inpatient Stay

Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician Hospital services 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.*

This plan covers inpatient hospitalization in a General Hospital for an unlimited number of days. Combined Network and Non-Network Benefits at Specialty Hospitals or in a General Hospital for specialty services are limited to 45 days per calendar year. If you are readmitted after ninety (90) days, we consider this to be a new period of hospitalization for the purpose of determining the hospital days available to you.

Preauthorization is recommended at non-network facilities.

	Your Copayment Amount	Does Copayment Help Meet Out-of-Pocket Maximum?
Network	No Copayment	No
Non-Network	20%	Yes

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
17. Infertility Services (Effective 7/01/07)	***Network***	20%	No
	Non-Network	20%	No

17. Infertility Services (Effective 7/01/07)

Services for the diagnosis and treatment of infertility for women when provided by or under the direction of a Physician and deemed medically necessary.

Includes oral or injectable infertility drugs not obtained at the pharmacy.

Infertility is defined as a condition of an otherwise presumably healthy married individual who is unable to conceive or sustain a pregnancy during a period of one year.

Benefits also include:

- Oral and injectable infertility drugs not obtained at the pharmacy.
- Donor gametes if provided through an approved program; if:
  - Married; and
  - Unable to conceive or sustain a pregnancy during a one year period.

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
18. Injections received in a Physician's Office Benefits are available for injections received in a Physician's office. Oral or injectable chemotherapy drugs, if used for other than cancer treatment and not otherwise covered under the prescription drug section, are covered as a medical service and subject to a 20% copayment for both network and non-network coverage.	***Network***	20% per injection ***Allergy*** $10 per visit No Copayment applies when no Physician charge is assessed.	No
	Non-Network	20% per injection	No
19. Lyme Disease Coverage for diagnostic testing and long-term antibiotic treatment of chronic lyme disease when determined to be medically necessary and ordered by a physician after making a thorough evaluation of the patient’s symptoms, diagnostic test results and response to treatment. Treatment otherwise eligible for benefits pursuant to this section shall not be denied solely because such treatment may be characterized as unproven, experimental, or investigational in nature.	***Network***	No Copayment	No
	Non-Network	No Copayment	No

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
20. Maternity Services Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This plan covers physician services (including the services of a licensed midwife) for all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. Physician and midwife services combined are not covered for more than our allowance.	***Network***	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Diagnostic and Therapeutic Services.	
This includes newborn screening tests for metabolic, endocrine and hemoglobinopathy disorders. There are special prenatal programs to help during Pregnancy, including hospital-based classes on breastfeeding, caring for your infant, and early pregnancy. They are completely voluntary and there is no extra cost for participating in the program. 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.		No Copayment applies to Physician office visits for prenatal care after the first visit in which a $10 copayment applies.	

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?

- One lactation support out-patient visit or home visit is covered when ordered by the child's physician. Appointment must occur within 7 days after hospital discharge.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. This decision shall be made in accordance with the standards for guidelines for prenatal care published by the American College of Obstetrics and Gynecology and the American Academy of Pediatrics.

Non-Network

Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.

In those cases where you and your infant participate in an early discharge, you will be eligible for:

(a) 2 home care visits by a skilled, specially trained registered nurse for you and/or your infant, and additional visits reviewed by a Physician for medical necessity;
(b) Parent education, assistance and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests or any other tests or services related thereto; and
(c) A pediatric office visit within 24 hours after discharge.

The newborn is automatically covered for the first 31 days (this does not include newborns of dependent children).

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
21. Mental Health and Substance Abuse Services - Outpatient Mental Health Services for Mental Illness and Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, which we have approved, including: • Mental health, substance abuse and chemical dependency evaluations and assessment. • Diagnosis. • Treatment planning. • Referral services. • Medication management. • Short-term individual, family and group therapeutic services (including intensive outpatient therapy). • Crisis intervention.	***Network***	$10 per individual visit $10 per group visit	No
Any combination of Network and Non-Network Benefits for Mental Health Services (excluding visits for medication management) is limited to 45 visits per calendar year. Any combination of Network and Non-Network Benefits for Substance Abuse Services is limited to 30 hours per member per calendar year.	***Non-Network***	20%	Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?

This plan covers the following outpatient mental health specialists and services up to the maximum number of visits listed above.

- Board certified psychiatrists; licensed clinical psychologists, clinical social workers (licensed or certified at the Independent practice level – "Certified Independent Social Worker");
- Licensed nurse clinicians (with MRN degrees and certification by the ANA as a clinical specialist in psychiatric and mental health nursing); AND
- Licensed Marriage and Family Therapists.

The above providers must be licensed and certified in the state where you receive the service and must meet our credentialing criteria.

Day Care:

This Plan covers the following psychiatric day care services for eight (8) hours a day in an approved psychiatric day care program. It must be medically necessary that you receive supervised care through that program two or more times per week for a continuous eight (8) hour period each time:

- Appropriate Hospital services;
- Professional and other staff services performed by employees of the facility under the supervision of a staff psychiatrist; AND

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?

- A maximum of four (4) family therapy sessions for members of your family with mental health professionals employed by the facility.

Transitional Outpatient Services:

Transitional outpatient services are used as a step down from a higher level of care or a step-up from standard outpatient care. This Plan covers the following transitional outpatient services:

- **Intensive Outpatient Program** - Individual and group therapy with medication management for a minimum of three (3) hours per day, normally three (3) days per week. This program provides substantial clinical support for patients who are either in transition from the Hospital to any outpatient setting or at risk for admission to inpatient care or other higher levels of care.
- **Adult and Child Intensive Services** - Services include up to seven (7) visits per week, consisting of ongoing emergency/crisis evaluations, out of home respite, psychiatric assessment, medication evaluation, case management, nursing services, and outpatient therapy.
- **Facility Home Based Treatment** - Individual or family therapy and/or medication management provided in the patient's home.

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
Shock Therapy This Plan covers electroshock therapy services when performed and billed by a Physician. This Plan does NOT cover Physician visits and outpatient mental health visits on the same day that electro-shock therapy was performed. Anesthesia administered to you for shock therapy is covered provided it is not administered by the same Physician who is performing the shock therapy.			
22. Mental Health and Substance Abuse Services - Inpatient and Intermediate Mental Health Services for Mental Illness and Substance Abuse Services received on an inpatient or intermediate care basis in a Hospital or an Alternate Facility. Substance Abuse Services received as community residential care services. Benefits include detoxification from abusive chemicals or substances that is limited to physical detoxification when necessary to protect your physical health and well-being. For purposes of determining coverage, two (2) days of outpatient chemical dependency detoxification count as one (1) day of inpatient detoxification. Two (2) days in an outpatient partial Hospital program count as one (1) day of intensive rehabilitation treatment. Three (3) days in an intensive outpatient program count as (1) day of intensive rehabilitation treatment.	***Network***	No Copayment	No

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
If an Inpatient Stay is required, it is covered on a Semi-private Room basis. If any provisions of Section 15 – Hospital Inpatient Stay are different from the provisions of this section, the provisions of this section shall apply and govern for inpatient substance abuse treatment. Any combination of Network and Non-Network Benefits for Substance Abuse Services is limited to thirty (30) days per calendar year. Any combination of Network and Non-Network Benefits for Substance Abuse Services for detoxification is limited to five (5) detoxification occurrences or thirty (30) days per calendar year, whichever comes first. Pre-authorization is recommended for this service.	***Non-Network***	20%	Yes

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
23. Nutritional Counseling	***Network***	$10 per visit	No
	Non-Network	20%	Yes

23. Nutritional Counseling

Covered Health Services provided by a registered dietician in an individual session for Covered Persons with medical conditions that require a special diet. Examples of such medical conditions include, but not limited to:

- Diabetes mellitus.
- Morbid obesity.
- Coronary artery disease.
- Congestive heart failure.
- Severe obstructive airway disease.
- Gout.
- Renal failure.
- Phenylketonuria.
- Hyperlipidemias.

Benefits are limited to six visits per calendar year when prescribed by a Physician for treatment of an illness.

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
24. Outpatient Surgery and Therapeutic Services			
Outpatient Surgery Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this section include only the facility charge and the charge for required Hospital-based professional services, supplies and equipment. Benefits for the surgeon fees related to outpatient surgery are described under *Professional Fees for Surgical and Medical Services*.	***Network***	No Copayment	No
When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.	***Non-Network***	20%	Yes

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
25. Physician's Office Services **Covered Health Services received in a Physician's office including:**	***Network***	$10 per visit No Copayment applies when no Physician charge is assessed. No Copayment applies for flu shots.	No
• Diagnosis and treatment of a Sickness or Injury. • Preventive medical care. (Copayment does not apply) • Well-baby and well-child care, including immunizations in accordance with American Academy of Pediatrics guidelines. (Copayment does not apply) • Birth – 12 months is limited to 7 visits. 13-35 months is limited to 3 visits. 36 months – 19 years is limited to one per calendar year. • Routine physical examinations and an annual OB/GYN examination. (Copayment does not apply) • Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment.) • The following adult immunizations: Hepatitis B, Influenza, Pneumonia, Tetanus, and Lyme Disease (covered for individuals aged 15-70 who live, work, or recreate in areas of high or moderate risk or whose exposure to tick-infested habitat is frequent or prolonged.) • Allergists', Dermatologists', and Podiatrists' office visits are covered. • Pain Management (Copayment does not apply)	***Non-Network***	20%	Yes

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
Hospital based clinic visits are considered office visits and are subject to the office visit copayment listed. See Section 17 for information related to coverage of injections received in a Physician's office. **Cancer treatment in a Physician's office** Chemotherapy: This plan covers oral and injectable anti-neoplastic prescription drugs when they are approved by us and are used solely for the purpose of cancer treatment. This plan covers physician services for administration of chemotherapy. <u>Radiation Therapy: This plan covers physician services for radiation therapy received in a physician's office. Radiation physics, dosimetry services, treatment devices, and hospital services are included in radiation treatment planning and therapy and are covered as part of our allowance for radiation therapy.</u>	***Network***	$10 per visit No Copayment applies when no Physician charge is assessed.	No
	Non-Network	20%	No

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
26. Private Duty Nursing Services Private duty nursing care given on an inpatient basis in a General Hospital or in your home by a licensed nurse (R.N., L.P.N., or L.V.N.) when no intensive care unit is available and it is medically necessary. This plan does not cover:	***Network***	No Copayment	No
• Services of a nurse's aide; • Charges for private duty nursing when primary duties are limited to bathing, feeding, exercising, homemaking, giving oral medications, or acting as companion or sitter, OR • Private duty nursing due to a shortage of hospital nursing staff. Preauthorization is recommended for this Non-Network service.	***Non-Network***	No Copayment	No
27. 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. This Plan covers physicians' visits in your home only if you have a condition resulting from an injury and illness which confines you to your home, requires special transportation or requires the assistance of another person.	***Network***	No Copayment ***House Calls*** $10 per visit	No

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
Surgery is only covered if the physician is licensed to perform the surgery. If a surgery is performed to diagnose an illness or condition, this Plan covers it. This Plan does not cover the diagnostic surgery if it is immediately followed by related surgery to treat that condition. If you are admitted to a General Hospital as an inpatient, this Plan covers the services of a physician in charge of your care, up to one (1) visit per day. Other physician visits are limited to one visit per day per specialty. Kidney, cornea, and allogenic bone marrow transplants are considered general surgery procedures for the purposes of this plan. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above. In addition to the type and purpose of surgery, your coverage differs depending on the number of surgeons involved. If two (2) surgeons perform separate operations during a single surgical session, each surgeon may submit a claim reporting the procedure performed and the circumstances involved. These claims will then be evaluated for payment on an individual basis. This Plan does NOT cover the services of an assistant surgeon for all surgeries. If we determine that it is medically necessary to use the services of an assistant surgeon during an operation, these services are covered only if he or she is a private practice Physician, not a Hospital employee. Your surgeon can not be paid as both the surgeon and assisting surgeon during the same surgical session.	***Non-Network***	20%	Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?

This Plan does NOT cover the standby services of an assistant surgeon.

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

In addition to the type and purpose of surgery, your coverage differs depending on the number of surgeons involved. If two (2) surgeons perform separate operations during a single surgical session, each surgeon may submit a claim reporting the procedure performed and the circumstances involved. These claims will then be evaluated for payment on an individual basis.

This Plan does NOT cover the services of an assistant surgeon for all surgeries. If we determine that it is medically necessary to use the services of an assistant surgeon during an operation, these services are covered only if he or she is a private practice Physician, not a Hospital employee. Your surgeon can not be paid as both the surgeon and assisting surgeon during the same surgical session.

This Plan does NOT cover the standby services of an assistant surgeon.

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
If, while you are in the hospital, the attending physician in charge of your care requests the assistance of a physician who has special skills and knowledge to diagnose your condition, this Plan covers one specialist visit/one consultation per specialty per period of hospitalization. The transferring of a patient from one physician to another is not considered to be a consultation. A specialized physician who then treats you as his/her patient is not considered to be a consultant. Note that this Plan does NOT cover pathology consultations, telephone consultations or follow-up consultations.			
28. Prosthetic Devices The following prosthetic devices that replace a limb or an external body part, including the replacement, repair or adjustment of these appliances (replacements will be allowed only if there is a change in your medical condition). Benefit includes the purchase of the devices and accessories and/or supplies necessary for attachment to an operation of prosthetic devices. • 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***	***Inpatient*** No Copayment ***Outpatient*** 20%	 No No

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
• Prosthetic devices which replace or substitute all or a part of an internal body part (including contiguous tissue), or replace all or part of the function of a permanently inoperative or malfunctioning body part necessary to alleviate an illness, injury or congenital defect.			
If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.	***Non-Network***	***Inpatient*** 20%	Yes
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.		***Outpatient*** 20%	No
29. Reconstructive Procedures/ Mastectomy Services 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.	***Network***	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.	

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
Cosmetic Services 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. This Plan covers the following procedures to treat functional impairments, when medically necessary. • Reduction Mammoplasty; • Prophylactic Mastectomy; • Removal of Breast Implants; • Blepharoplasty; • Ptosis Repair; • Panniculectomy; • Abdominoplasty; • Repair of Pectus Excavatum; • Septorhinoplasty; • Nasal Reconstruction; • Removal/Treatment of Symptomatic Benign Skin Lesions; • Removal/Treatment of Poliferative Vascular Lesions and Hemangiomas;	***Non-Network***	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.	

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?

- Treatment of Varicose Vein; and
- Orthognathic surgery including Mandibular and Maxillary Osteotomy.

Determinations for coverage of the above procedures may require review of medical documentation including history and physical, preoperative diagnostic studies, previously attempted conservative medical therapy and photographs or other medical records.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service.

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
Following a mastectomy, coverage includes a minimum of 48 hours in a Hospital and a minimum of 24 hours in a Hospital following an auxiliary node dissection. Any decision to shorten these minimum coverage's shall be made by the attending Physician in consultation with and upon agreement with the patient. If the patient participates in an early discharge, defined as inpatient care following a mastectomy that is less than 48 hours and inpatient care following auxiliary node dissection that is less than 24 hours, coverage shall include a minimum of 1 home visit conducted by a Physician or registered nurse. You can contact the Claims Administrator at the telephone number on your ID card for more information about Benefits for mastectomy-related services.			
30. Rehabilitation Services - Outpatient Therapy Short-term outpatient rehabilitation services for: • Physical and Occupational therapy. • Speech therapy. • Physical and/or occupational therapy is covered only when a program is implemented to restore the highest level of independent functioning in the most timely manner possible AND: • we determine that the therapy will result in significant, sustained, measurable functional/anatomical improvement of your condition; AND	***Network***	No Copayment applies for Physical or Occupational therapy within 30 days following a related Hospital stay, home care program, or ambulatory surgical procedure, otherwise 20%.	No

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
• such improvement will not diminish with the removal of the therapeutic agent or environment.		20% applies to Speech therapy outpatient or physician's office	
Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician.	***Non-Network***	20%	Yes, if therapy is within 30 days following a related hospital stay, home care program or ambulatory surgical procedure, otherwise No.

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
31. Rehabilitation Services – Cardiac Therapy	***Outpatient Network***	20%	No
This Plan covers visits in a cardiac rehabilitation program, if the physician and facility are specifically accredited to perform cardiac rehabilitation and the following conditions are met:	***Outpatient Non-Network***	20%	No
	Inpatient Network	No Copayment	No
	Inpatient Non-Network	20%	Yes

- Acute myocardial infarction within the previous twelve (12) months from the start of cardiac rehabilitation.
- Following coronary artery bypass graft surgery within the preceding twelve (12) months. Cardiac rehabilitation must begin within six (6) months of the coronary artery bypass graft surgery.
- Following percutaneous transluminal coronary angioplasty.
- Following valve replacements or repairs.
- Stable angina pectoris: all patients must have had a pre-entry stress test that is positive for exercise induced ischemia within six (6) months of starting cardiac rehabilitation. The positive stress test should include perfusion studies demonstrating the ischemia.
- Compensated heart failure.
- Post-heart transplantation.

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
Outpatient cardiac rehabilitation therapy limited to 3 visits per week up to 12 weeks combined Network and Non-Network benefits. If received on an inpatient basis, Cardiac rehabilitation therapy is limited to 12 weeks or 36 visits, whichever comes first (and includes combined Network and Non-Network benefits).			

32. Respiratory Therapy – Outpatient/In a Physician's Office

This Plan covers short-term outpatient respiratory therapy or respiratory therapy received in a Physician's office when your Physician orders the therapy under the following conditions:

(a) As part of a therapeutic program for up to fourteen (14) days before admitting you to the Hospital; OR

(b) Up to six (6) weeks after you have been discharged from the Hospital.

This plan does NOT cover respiratory therapy services when received in your home unless received through a pre-authorized home care program or hospice care program.

	Your Copayment Amount	Does Copayment Help Meet Out-of-Pocket Maximum?
Network	No Copayment	No
Non-Network	20%	Yes

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
33. 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 Copayment	No
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. Preauthorization is recommended.	***Non-Network***	20%	Yes
34. Smoking Cessation (Effective 01/01/07) Tobacco cessation programs. Smoking cessation treatment includes the use of an over-the-counter (OTC) or prescription FDA approved nicotine replacement therapy, when prescribed by a provider. Includes an annual outpatient benefit of eight (8) one half (1/2) hour smoking cessation counseling sessions provided by a qualified practitioner for each covered individual.	***Network***	Appropriate prescription and outpatient counseling copayments apply	No

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
	Non-Network	Appropriate prescription and outpatient counseling copayments apply	Yes
35. Speech Therapy - Outpatient/In a Physician's Office This plan covers short-term outpatient speech therapy services or speech therapy services received in a registered therapist's office only when the speech impediment or speech dysfunction results from Injury, stroke, or a Congenital Anomaly and therapy is received from a registered therapist as part of a formal treatment plan. This plan does NOT cover these services if such services are or would have been provided under state or federal laws which provide service for the health of school children or handicapped children (see generally, Title 16, Chapters 21, 24, 25 and 26 of the R. I. Gen. Laws and applicable regulations governing health of school children and the special education of handicapped children or comparable requirements established by federal law.)	***Network***	20%	No
	Non-Network	20%	No

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
This plan does NOT cover speech therapy services received in your home unless it is part of an approved home care program.			
36. Transplantation Services Covered Health Services for the following organ and tissue transplants when ordered by a Physician. Transplantation services must be received at a Designated Facility. Benefits are available for the transplants listed below when the transplant meets the definition of a Covered Health Service, and is not an Experimental, Investigational or Unproven Service: • 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. • Autologous bone marrow transplantation (in which the patient is his or her own donor) with high dose chemotherapy or radiation is only covered for the following conditions: (a) State III or IV Hodgkin's disease which has recurred after an initial complete remission with no bone marrow involvement; (b) State III or IV Intermediate or high grade non-Hodgkin's lymphoma which has recurred after an initial complete remission with no bone marrow involvement; (c) State III or IV Neuroblastoma without bone marrow involvement; AND	***Designated Facilities***	No Copayment	No
	Non-Network	Non-Network Benefits are not available.	Non-Network Benefits are not available.

To the extent that coverage for autologous bone marrow transplantation, as set forth in subsections (a) through (d) above, is more limited than the coverage required to be covered for "New Cancer Therapies," the applicable provisions of the Rhode Island General Laws shall govern. (See Section 2: Cancer Therapies – Investigational.)

Related Exclusion

This plan does NOT cover autologous bone marrow transplantation (with high dose chemotherapy and/or radiation) except as provided in this section and Section 2: Cancer Therapies – Investigational. This exclusion pertains to, but is not limited to, the following treatments:

- Acute leukemia in first remission;
- Hodgkin's or non-Hodgkin's lymphoma in first remission;
- Breast cancer;
- Intrinsic brain tumors;
- Ovarian cancer;
- Lung cancer;
- Testicular cancer;
- Colon cancer;
- Wilm's tumor; AND

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?

- Acquired immunodeficiency syndrome and human immunovirus infection.
- Allogenic Bone Marrow Transplants are covered. This includes medical and surgical services for the matching participant donor and the recipient. Costs associated with donor searches are covered up to a maximum of $25,000 only if the transplant is performed at a Designated Facility. Costs associated with donor searches are not covered if the transplant is not performed at a Designated Facility.
- Benefits are available for one human leukocyte antigen testing per lifetime or histocompatibility locus antigen testing that is necessary to establish bone marrow transplant donor suitability, including testing for A, B or DR antigens, or any combination of those tests. The testing must be performed in a facility which is:
  - (a) accredited by the American Association of Blood Banks or its successors; and
  - (b) licensed under the Clinical Laboratory Improvement Act as it may be amended from time to time.

At the time of testing, the person being tested must complete and sign an informed consent form which also authorizes the results of the test to be used for participation in the National Marrow Donor program.

- Heart transplants.
- Heart/lung transplants.

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
• Lung transplants. • Kidney transplants. • Kidney/pancreas transplants. • Liver transplants. • Liver/small bowel transplants. • Pancreas transplants. • Small bowel transplants. Covered Hospital Services for transplants include: obtaining donated organs (including removal from a cadaver), donor medical and surgical expenses related to obtaining the organ, and transportation of the organ from donor to recipient.			
The transplant benefit period begins five days before a covered organ transplant and continues through one year afterwards. During a benefit period, this plan covers the following services: (a) covered hospital expenses; (b) the physician's fee you are charged for surgical, medical and other services related to a covered organ transplant when these services are performed, ordered or supervised by a physician. (c) additional transplant charges for medically necessary services and supplies during a transplant benefit period if they are not covered under this plan. They must be performed, ordered and/or supervised by a physician.	***Network***	**Human Leukocyte Antigen Testing** No Copayment	No

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
Network Benefits are available for cornea, kidney, allogenic bone marrow transplants and Human Leukocyte Antigen Testing that are provided by a Network Physician at a Network Hospital. We do not require that cornea, kidney, allogenic bone marrow transplants or Human Leukocyte Antigen Testing be performed at a Designated Facility in order for you to receive Network Benefits. 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 those listed above are excluded from coverage. **Transportation and Lodging** The services described under **Transportation and Lodging** below are Covered Health Services **ONLY** in connection with a transplant received at a Designated Facility. The Claims Administrator will assist the patient and family with travel and lodging arrangements ONLY when services are received from a Designated Facility. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows: • Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.	***Non-Network***	20%	Yes

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
• Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Designated Facility. There is a combined overall maximum Benefit of $5,000 per Covered Person per Transplant for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures.			
37. 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. No copayment applies for a flu shot in network. A 20% copayment is assessed out of network.	***Network***	$10 per visit	No
	Non-Network	20%	Yes

Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
38. Wigs (Effective 01/01/07) Coverage for scalp hair prosthesis worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia, provided, however, that such coverage shall be subject to the same limitations and guidelines as other prosthesis, and that coverage shall not exceed an amount of three hundred fifty dollars ($350) per covered member per year, exclusive of any deductible. A prescription from a Physician is required and a wig must be purchased from a Durable Medical Equipment Provider.	***Network***	20%	No
	Non-Network	20%	No

Section 2: What's Not Covered--Exclusions

This section contains information about:

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

How We Use Headings in this Section

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

We Do not Pay Benefits for Exclusions

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

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

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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. Recreational Therapy.
7. Pet Therapy.
8. Aqua Therapy.
9. Maintenance Therapy.
10. Pelvic floor electrical stimulation, biofeed training, pelvic floor exercises, and any other exercise therapy.
11. Biofeed back by any modality.
12. Therapies, procedures, and services for purposes of relieving stress.
13. 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 and radio.
2. Telephone.
3. Beauty/Barber service.
4. Guest service.

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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.
   - Recliner lifts.
   - Electric scooters.
6. Devices and computers to assist in communication and speech.

C. Dental

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

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   - 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.
7. This Plan does not cover general dental services such as extraction (including full mouth extractions), prostheses, braces, operative restorations, fillings, medical or surgical treatments or dental caries, gingivitis, impactions, periodontal surgery, non-surgical treatment of TMJ, including appliances or restorations necessary to increase vertical dimensions or to restore the occlusion, anesthesia administered in a dentist's office, anorexia x-rays or dental x-rays.
8. This Plan does not cover dental appliances or devices.
9. This Plan does not cover injuries incurred as a result of biting/chewing.
10. This Plan does not cover any preparation of the mouth for dentures and/or dental or oral surgeries such as but not limited to;
    - Apicoectomy, per tooth, first root;
    - Removal of partially bony impacted tooth;
    - Surgical removal of partial bony impaction;
    - Removal of completely bony impacted tooth, with or without unusual surgical complications;
    - Surgical removal of residual tooth roots;
    - Vestibuloplasty with skin mucosal graft and lowering the floor of the mouth;
    - Complete surgical removal of inaccessible impacted mandibular tooth mesial surface;
    - Surgical removal of impacted maxillary tooth;

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- Operculectomy excision pericoronal tissues;
- Excision of feberous tuberosities;
- Excision of hyperplastic alveolar mucosa, each quadrant;
- Alveolectomy including curettage of osteitis or sequestrectomy; and
- Alceoplasty, each quadrant.

D. Drugs

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

E. Experimental, Investigational or Unproven Services

Experimental, Investigational and Unproven Services are excluded except as described in (Section 1: What's Covered--Benefits) under the heading *Cancer Therapies - Investigational and Lyme Disease*. 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.

We have the right and discretionary authority to determine whether a service is experimental/investigational, and any such determination made by us in good faith is binding on you.

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F. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - — Elastic stockings.
   - — Ace bandages.
   - — Gauze and dressings.
   - — Alcohol swabs.
3. Corrective shoes and orthotic devices used in connection with footwear.
4. Tubings and masks are not covered except when used with Durable Medical Equipment as described in (Section 1: What's Covered—Benefits).
5. Pillows supplied by a Chiropractic Physician.

G. Mental Health/Substance Abuse

1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
2. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following:
   - — Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
   - — Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.

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

The Mental Health/Substance Abuse Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

3. Substance Abuse treatment services received in your home.
4. Recreation therapy, non-medical self-care, or self-help training.
5. Residential treatment for mental health services, or those services performed in a residential treatment facility, or a portion of a hospital used for residential treatment purposes.
6. Services performed at substance abuse facilities that are not approved and licensed by the state. This Plan covers services of a network hospital or treatment facility or a non-network hospital or treatment facility that meets our criteria for participation. If it can be established through a preadmission certification process that the service is not available at a hospital or facility that meets our criteria for participation we may then cover the services of a non-network hospital or facility that does not meet our criteria for participation.
7. Mental, family or other counseling or training services unless the member is diagnosed with a mental disorder.

H. 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. Nutritional and electrolyte supplements, including infant formula and donor breast milk.

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I. 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;
   - — Correction of variations in normal anatomy including augmentation mammoplasty and correction of congenital breast symmetry;
   - — Rhinoplasty;
   - — Rhytidectomy;
   - — Genioplasty;
   - — Otoplasty;
   - — Cervicoplasty;
   - — Osteoplasty: Facial Bone Reduction;
   - — Scar Revision;
   - — Excision of Excess Skin or Subcutaneous Tissue;
   - — Subcutaneous Injection of Filling Material;
   - — Removal of Asymptomatic Benign Skin Lesions;
   - — Dermabrasion
   - — Chemical Peel;
   - — Chemical Exfoliation for Acne;
   - — Suction assisted Lipectomy as Primary Procedure;

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- Hair Transplants;
- Electrolysis Epilation;
- Procedures to correct visual acuity including, but not limited to, Radial Keratotomy;
- Ear Piercing; and
- Sclerotherapy for Spider Veins.

Medically necessary surgery performed at the same time as a cosmetic procedure is NOT covered. (For example, septoplasty or submucous resection performed in connection with rhinoplasty).

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. This Plan does not cover health care services, including drugs, related to programs/procedures designed for the purpose of weight loss, such as, but not limited to, commercial diet plans, weight loss programs, and any services in connection with such plans or programs.

J. 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.
4. Services received in a facility primarily designed to care for students, facility, or employees of a college or other institution of learning.
5. Services in convalescent homes, home for the aged, halfway houses or other residential facilities.

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6. Services performed by a physician, surgeon, or other person who is not legally qualified or licensed according to relevant sections of RI General Laws or other governing bodies or who does not meet our credentialing requirement.
7. Services of Christian Science Practitioners.
8. Hemodialysis services received in a physician's office.
9. Extra charges for a private hospital room are not covered if a semi-private room is available.

K. Reproduction

Services related to:

1. Surrogate parenting.
2. The reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal).
3. Health services and associated expenses for elective abortion.
4. Fetal reduction surgery.
5. Health services associated with the use of non-surgical or drug-induced Pregnancy termination.
6. Freezing and storage of gametes, sperm, embryos, and other specimen for future use.
7. Genetic counseling and amniocenteses or any other service used to determine the sex of an infant before it is born.

L. Services Provided under Another Plan/Available from Other Sources

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

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required by workers' compensation, no-fault auto insurance, or similar legislation.

   Health care services performed to treat work-related illnesses, conditions, or injuries, whether or not the member is covered by Workers' Compensation law, unless the member is self-employed or a member of a partnership and such work-related illness, conditions, or injuries were incurred in the course of the self-employment or partnership activities.
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.
4. Services when the member can recover all or a portion of the cost of such services through a federal, state, county, or municipal law or through legal action. This is true even if the member chooses not to assert his/her rights under these laws

M. Transplants

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

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N. 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.

O. Vision

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

P. Diagnostic Tests

This Plan does NOT cover the following x-rays:

- Perineograms;
- Xeroradiography;
- Myocardial imaging;
- Positron emission tomography (PET);
- Fluoroscopic chest x-ray; and
- Any imaging for screening purposes (except for mammograms as described above).

This Plan does NOT cover the following tests:

- Bone marrow blood supply MRIs;

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- Electrocardiograms to determine anesthesia risk; magnetic resonance angiography of the pelvis and/or upper or lower extremities;
- Transtelephonic EKGs; and
- Telephone pacemaker monitoring.

This plan does NOT cover lab tests for screening purposes (except Pap Smears, PSA and colorectal lab tests as described above). This plan does NOT cover genetic testing for screening purposes.

This plan does NOT cover audiometric hearing or speech services if such services are or would have been provided under state or federal laws which provide service for the health of school children or handicapped children. (See generally, Title 16, Chapters 21, 24, 25, and 26 of the Rhode Island General Laws and applicable regulations governing the health of school children and the special education of handicapped children or comparable requirements established by federal law or state law of applicable jurisdiction.)

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. Adult vaccinations/immunizations for Meningitis, Measles, Mumps, and Rubella.
4. 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.
5. Except as otherwise provided in "Section 8: When Coverage Ends", 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.
6. 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.
7. In the event that a non-Network provider waives Copayments for a particular health service, no Benefits are provided for the health service for which the Copayments are waived.
8. Charges in excess of Eligible Expenses or in excess of any specified limitation.
9. Non-surgical services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered to be medical or dental in nature.
10. Surgical and Non-surgical treatment of obesity, including morbid obesity excluding those deemed by a Physician medically necessary.
11. Private duty nursing provided on an outpatient basis.
12. Growth hormone therapy.
13. Sex transformation operations and health care services related to sex transformations.
14. Custodial Care, day care, or non-skilled care.
15. Domiciliary care.

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16. Respite care.
17. Rest cures.
18. Psychosurgery.
19. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea excluding those deemed by a Physician medically necessary.
20. Oral appliances for snoring excluding those deemed by a Physician medically necessary as part of treatment for documented obstructive sleep apnea.
21. Except as otherwise provided in "Section 1: What's Covered – Benefits", speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly.
22. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
23. Any charge for services, supplies or equipment advertised by the provider as free.
24. Any charges prohibited by federal anti-kickback or self-referral statutes.
25. Repeated cauterizations or electrofulguration methods used to remove growths on the skin.
26. Fluoroscopy without films.
27. Psychoanalysis or psychotherapy services you receive which are credited towards a degree or to further your education or training regardless of symptoms that you may have.
28. Supervision of maintenance therapy for chronic disease which is aggravated by surgery and would not ordinarily require hospitalization.
29. Rehabilitation for maintenance purposes.

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

30. Procedures to determine post-operative fluid or electrolyte balance.
31. Gene therapy.
32. Any services related to drawing, processing or storage of your own blood.
33. Whole blood, red blood cells, blood replacement and penalty fees.
34. Charges for services and supplies required under the laws of a state other than the State of Rhode Island and which are not provided under this plan.
35. Services that may in and of themselves otherwise be covered, when provided attendant to a non-covered course of service or as a component of a non-covered regimen of care.
36. The following expenses related to receiving hemodialysis services in the home: installation or modification of electric power, water and sanitary disposal or changes for these services, moving expenses for relocating the machine, installation expenses not necessary to operate the machine or to train you or member of your family in the operation of the machine.
37. Thighplasty, brachioplasty and mastopexy.

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Section 3: Description of Network and Non-Network Benefits

This section includes information about:

- Network Benefits.
- Non-Network Benefits.
- Your responsibility for notification.
- 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:

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

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It is recommended that Mental Health and Substance Abuse Services be authorized by the Mental Health/Substance Abuse Designee for inpatient services. Please see Section 1: What's Covered--Benefits under the heading for *Mental Health and Substance Abuse*.

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	See Section 1: Notification Requirements.	See Section 1: Notification Requirements.
Who Should File Claims	Not required. Network providers are paid 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 pay any difference between Eligible Expenses and the amount the provider bills.	

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Provider Network

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

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

You will be given 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.

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.

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

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.

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

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 Physicians or non-Network providers. Non-Network Benefits are also payable for Covered Health Services that are provided at non-Network facilities.

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.

Your Responsibility for Notification

See Pre-Authorization in Section 1.

Care Coordination SM

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

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Emergency Health Services

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

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 48 hours 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

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

- the date such confinement or treatment ends; or
- thirty (30) days from the date the facility or provider are no longer part of the Network.

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+Choice (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 retiree 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 31 days of the date the Eligible Person becomes eligible to enroll.
Open Enrollment Period	Eligible Persons may enroll themselves and their Dependents.	The Plan Administrator determines the Open Enrollment Period. Coverage begins on the date identified by the Plan Administrator if the Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the date the Eligible Person becomes eligible to enroll.
New Eligible Persons	New Eligible Persons may enroll themselves and their Dependents.	Coverage begins on the date of hire if the Plan Administrator receives the properly completed enrollment form and any required contribution for coverage within 31 days of the date the new Eligible Person becomes eligible to enroll and if the Participant pays any required contribution to the Plan Administrator for Coverage. If you or your dependents fail to enroll at this time, you cannot enroll in the Plan unless you do so through an Open Enrollment Period or a Special Enrollment Period.

When to Enroll	Who Can Enroll	Begin Date
Adding New Dependents	Participants may enroll Dependents who join their family because of any of the following events: • Birth. • Legal adoption. • Placement for adoption. • Marriage. • Legal guardianship. • Court or administrative order. • Registering a Common Law Spouse. • Registering a Domestic Partner.	Coverage begins on the date of the event if the Plan Administrator received the completed enrollment form and any required contribution for coverage within 31 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.

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 and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and
- Coverage under the prior plan ended because of any of the following:
  - — Loss of eligibility (including, without limitation, legal separation, divorce, death, termination of employment, or a reduction in the number of hours of employment).

Event Takes Place (for example, a birth or marriage). Coverage begins on the date of the event if the Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the event.

Missed Initial Enrollment Period or Open Enrollment Period. Coverage begins on the day immediately following the day coverage under the prior plan ends if the Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the date coverage under the prior plan ended.

When to Enroll	Who Can Enroll	Begin Date
	— The employer stopped paying a contribution. 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.	

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 paying Copayments to a Network provider at the time of service, or when you receive a bill from the provider.

Network providers file claims for you and must do so within ninety (90) days of providing a covered service to you.

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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 all claims within ninety (90) after receiving a covered service.

Failure to file the claim within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Participant, later than one (1) year from the time proof is otherwise required.

We will send you an Explanation of Benefits (EOB) whenever you have a coinsurance. Our payments to you or the provider fulfill our responsibility under this plan. Your benefits are personal to you and cannot be assigned, in whole or in part, to another person or organization.

Pharmacy Benefit Claims

If you are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy and you believe that the Plan should have paid for it, you may submit a claim for reimbursement as set forth in the procedures for filing a post-service group health plan claim (described in this section). If you pay a Copayment and you believe that the amount of the Copayment was incorrect, you also may submit a claim for reimbursement as set forth in the procedures for filing a post-service group health plan claim.

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If a retail or mail order pharmacy fails to fill a prescription that you have presented, you may contact the Claims Administrator by submitting a claim for coverage as set forth in the procedures for filing a pre-service health plan claim (described in this section).

Required Information

Non-Network providers may or may not file claims for you. If the Non-Network provider does not file the claim on your behalf, you will need to file the claim yourself. To file a claim, please send us an itemized bill including 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).

Payment of Benefits

Benefits are paid within the time frames shown below after the Claims Administrator receives a request for payment that includes all required information.

- 30 days after receipt of a request submitted by electronic means.

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- 40 days after receipt of a request submitted by other than electronic means.

Requests for payment that include all required information which are not paid within these time frames will include an overdue payment of interest at the rate of 12% per annum

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 and the provider 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.

Once all of the needed information is received, if the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received.

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 claim improperly, the Claims Administrator will notify you of the improper filing and how to

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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 all of the needed information is received, the Claims Administrator will notify you of the determination within 15 days after the information is received. 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.

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

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hours after the request was received. You then have 48 hours to provide the requested information.

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

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

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.

In the event that prior authorization of services is not available for an emergency service, that service will be deemed covered.

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 request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

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

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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, 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.
- We notify you that we will not be paying a claim because we have determined that a service or supply is excluded under the Plan.

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

What to Do First

Contact the Customer Service Department

The toll free telephone number is shown on your ID card.

Customer Service representatives are available to take your call during regular business hours, Monday through Friday. At other times, you may leave a message on voicemail. A Customer Service representative will return your call. If you would rather send your complaint in writing at this point, the Customer Service representative can provide you with the appropriate address. You

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will receive an acknowledgement letter within ten (10) business days of the Grievance and Appeal Unit's receipt of your written complaint or administrative appeal. If someone is filing a complaint on your behalf, you must send a notice to the Claims Administrator that the person has the authority to receive information on your behalf. This notice must be signed by you.

What to Do Next

If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint or file a verbal complaint on your behalf. The Claims Administrator will notify you of the decision regarding your complaint within 31 business days of receiving it. Your determination letter will provide you with information regarding the determination and your rights to further review if you are not satisfied with the outcome of the review and determination.

What to Do if You Disagree with The Decision If you disagree with the decision after following the above steps, you can ask for your complaint to be formally reconsidered.

If the complaint relates to a claim for payment, 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 new information to support your request for claim payment.

A committee will be appointed to resolve or recommend the resolution of the complaint. If your complaint is related to clinical

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matters, the committee will include health care professionals who did not make the first determination. Medical experts may be consulted or may participate in the complaint resolution process.

Level 1 Review

You may request a Level 1 review of any matter subject to medical appeal by making a request for such review to us within sixty (60) calendar days of the initial determination letter. You may request this review by calling Customer Service, but we strongly suggest you submit your request in writing to ensure your request is accurately reflected.

You will receive notification of the determination on a Level 1 review within fifteen (15) business days, or within twenty-one (21) business days if you are notified verbally within fifteen (15) business days following the receipt of all necessary medical information to conduct a review. The combined time to attempt to obtain medical information and complete the review will not exceed forty-five (45) business days from the receipt of your request for a Level 1 review. If you are requesting reconsideration (Level 1 review) of a service that was denied after you already obtained the service, then you will receive written notification of the determination within thirty (30) business days of the receipt of all necessary medical information.

Level 2 Review

You may request a Level 2 appeal review (preferably in writing) if the denial was upheld during the Level 1 review process. Your Level 2 appeal review will be reviewed by a provider in the same specialty as your treating provider. You must submit your request for a Level 2 appeal review within sixty (60) calendar days of the date of the reconsideration determination letter. Upon request for a Level 2 review, you will be provided with the opportunity to inspect the medical file and add information to the file. You will receive written notification of a determination on a Level 2 review within fifteen

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(15) business days, or within twenty-one (21) business days if you are notified verbally within fifteen (15) business days following the receipt of all necessary medical information to conduct a review. The combined time to attempt to obtain medical information and to complete the review will not exceed forty-five (45) business days from the receipt of your request for a Level 2 review. If the service you are requesting review of was denied after you already obtained the service (retrospectively), you will receive written notification of the determination within thirty (30) business days of the receipt of all necessary medical information.

What to Do if Your Complaint Requires Immediate Action

Your complaint requires immediate action when your Physician judges that a delay in treatment would significantly increase the risk to your health. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.

We will notify you of the decision by the end of the next business day after your appeal is received, unless more information is needed.

If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The complaint process for urgent situations does not apply to prescheduled treatments, therapies, surgeries or other procedures that we do not consider urgent situations.

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External Review

If you remain dissatisfied with the determination of the internal review processes (Level 1 and Level 2), you may request an external review by an outside agency. All such external reviews will be conducted in accordance with applicable state laws and regulations, including the Department of Health Rules and Regulations for the Utilization Review of Health Care Services. Information about this process will be included in the final determination letter you receive.

To request an external review, you must submit a written request to the Claims Administrator within sixty (60) calendar days of your receipt of the medical appeal denial notification. You will be permitted to select the external appeal agency that will perform the external appeal from a list of Department of Health approved agencies. You will be responsible for fifty percent (50%) of the charges and fees from the external agency and we will pay the remaining fifty-percent (50%). However, if the external appeal agency overturns the denial determination, you will be reimbursed for your half of the cost of the review agency's review. For all such appeals, the external appeal agency will notify you of its determination within ten (10) business days of the agency's receipt of the information.

Judicial Review

If you are dissatisfied with the final decision of the external appeal agency, you are entitled to a final review (A Judicial Review). This review will take place in an appropriate court of law.

Note: Once a member or provider receives a decision at one of the several levels of appeal (Level 1, Level 2, External and Judicial), no other party (provider or the member) may ask for an appeal at the same level again, unless additional information that could impact such decisions can be provided.

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Grievances Unrelated to Claims

We encourage you to discuss any complaint that you may have about any aspect of your medical treatment with the health care provider that furnished the care. In most cases, issues can be more easily resolved when they are raised when they occur. If however, you remain dissatisfied or prefer not to take up the issue with your provider, you may access the complaint and grievance procedures.

You may access the complaint and grievance procedures if you have a complaint about the service or regarding one of the employees of the Claims Administrator. In order to initiate a grievance, please call the Customer Service Department at the number on the back of your ID card. The Customer Service Department will log in your call and begin working towards the resolution of your complaint.

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Section 7: Coordination of Benefits

This section provides you with information about:

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

Benefits When You Have Coverage under More than One Plan

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

When Coordination of Benefits Applies

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

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

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

Definitions

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

1. "Coverage Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.
   a. "Coverage Plan" includes: (1) Group insurance or group-type coverage whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage. (2) Coverage under a governmental plan, or coverage required to be provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).
   b. "Coverage Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

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

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

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

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

3. "Allowable Expense" means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Coverage Plans is not an Allowable Expense. Dental care, routine vision care, and outpatient prescription drugs are examples of expenses or services that are not Allowable Expenses under the Plan. The following are additional examples of expenses or services that are not Allowable Expenses:

   a. If a Covered Person is confined in a private Hospital room, the difference between the cost of a Semi-private Room in the Hospital and the private room, (unless the patient's stay in a private Hospital room is medically necessary in terms of generally accepted medical practice, or one of the Coverage Plans routinely provides coverage for Hospital private rooms or there is no semi private room available) is not an Allowable Expense.

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   b. If a person is covered by two or more Coverage Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.

   c. If a person is covered by two or more Coverage Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

   d. If a person is covered by one Coverage Plan that calculates its benefits or services on the basis of usual and customary fees and another Coverage Plan that provides its benefits or services on the basis of negotiated fees, the Primary Coverage Plan's payment arrangements shall be the Allowable Expense for all Coverage Plans.

   e. The amount a benefit is reduced by the Primary Coverage Plan because a Covered Person does not comply with the Coverage Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

4. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.

5. "Closed Panel Plan" is a Coverage Plan that provides health benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

6. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with

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

Order of Benefit Determination Rules

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

A. The Primary Coverage Plan pays or provides its benefits as if the Secondary Coverage Plan or Coverage Plans did not exist.

B. A Coverage Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide out-of-network benefits.

C. A Coverage Plan may consider the benefits paid or provided by another Coverage Plan in determining its benefits only when it is secondary to that other Coverage Plan.

D. The first of the following rules that describes which Coverage Plan pays its benefits before another Coverage Plan is the rule to use.

   1. Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Coverage Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the

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

   2. Child Covered Under More Than One Coverage Plan. The order of benefits when a child is covered by more than one Coverage Plan is:

      a. The Primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:

         1) The parents are married;

         2) The parents are not separated (whether or not they ever have been married); or

         3) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

         If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.

      b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or plan years commencing after the Coverage Plan is given notice of the court decree.

      c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

         1) The Coverage Plan of the custodial parent;

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2) The Coverage Plan of the spouse of the custodial parent;
3) The Coverage Plan of the noncustodial parent; and then
4) The Coverage Plan of the spouse of the noncustodial parent.

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

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7. If the preceding rules do not determine the Primary Coverage Plan, the Allowable Expenses shall be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this provision. In addition, this Coverage Plan will not pay more than it would have paid had it been primary.

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

Effect on the Benefits of this Plan

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

If there is a benefit reserve, the Secondary Coverage Plan will use the Covered Person's benefit reserve to pay up to 100 percent of total Allowable Expenses incurred during the claim determination period.

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At the end of the claim determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

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

C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

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

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

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Right to Receive and Release Needed Information

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

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

Payments Made

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

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form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

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

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Section 8: When Coverage Ends

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

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

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, unless you are totally disabled and we 1) cease to offer medical coverage to our employees or 2) replace our self insured plan with a fully insured plan. (See "Continuation of Coverage and Conversion" in this section for limited circumstances providing continuation of coverage. – page 98.)

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

An Enrolled Dependent's coverage ends on the date the Participant's coverage ends unless otherwise specifically provided herein.

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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 date 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". (You will not become ineligible due to an adverse change in your health or the health status of any dependent.)
The Claims Administrator Receives Notice to End Coverage	Your coverage ends on the date 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.
Notification to Us	It is your obligation to promptly notify us of any event outlined herein that would be cause for coverage for you and/or your dependents to end (ex. Marriage of a child, death, loss of eligibility, attainment of a certain age, change in student status, divorce, legal separation or annulment, etc.).

Other Events Ending Your Coverage

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

Ending Event	What Happens
Fraud, Misrepresentation or False Information – Re: Eligibility for Coverage	Fraud or misrepresentation, or because the Participant knowingly gave us or the Claims Administrator false material information. Examples include false information relating to another person's eligibility or status as a Dependent. During the first two years the Plan is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.
Material Violation	There was a material violation of the terms of the Plan.
Improper Use of ID Card	You permitted an unauthorized person to use your ID card, or you used another person's card.
Failure to Pay	You failed to pay a required contribution.
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

If you have an unmarried child of any age who is medically certified as disabled and is chiefly dependent on you for support and care because of a mental impairment or physical disability which can be expected to result in death or can be expected to last for a continuous period of not less than 12 months, that child may be an eligible Enrolled Dependent under the terms of the Policy.

If you have a child that you believe is a Disabled Dependent, you will need to furnish us with proof of the medical certification of disability. We may require that a Physician chosen by us examine the child. We will pay for that examination.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Policy.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

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Continuation of Coverage and Conversion

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.

If an Eligible Person leaves state employment because of involuntary lay off as a result of the workplace ceasing to exist or the permanent reduction in size of the workforce, the benefits under the Plan or a spouse's coverage under the Plan may be continued under the provision R.I. Gen. Laws 27-19.1-1, as amended. If an Eligible Person dies, his/her spouse's coverage may be continued under the same law.

If We cease to offer medical coverage to our employees or replace our self-insured medical plan with a fully-insured medical plan, limited coverage will continue for twelve (12) months for those members who are totally disabled on the day the Plan ends and require continued care. Services will be covered if:

- the service provided is a Covered Health Service under the Plan; AND
- the care received relates to or arises out of the disability that existed on the day the Plan ended.

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Such extended benefits ONLY apply if you are totally disabled. If you desire to receive this coverage, you must provide us with proof of total disability. Your coverage will NOT be continued if you become eligible for coverage under another employer/agent's plan.

Continuation Coverage under Federal Law (COBRA)

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

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

- A Participant.
- A Participant's Enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law. However, domestic partners of Participants are not eligible for continuation coverage under federal law (COBRA).
- 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

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Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

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

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

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

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

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

Notification Requirements for Qualifying Event

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

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

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

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

Notification Requirements for Disability Determination or Change in Disability Status

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

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Continuation Coverage under federal law (COBRA)", subsection A. below.

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

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

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

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

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for

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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:

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 event A.).

   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. 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:

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   — 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.

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

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

   — Eighteen months from the date of the Participant's Medicare entitlement; or

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- 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
  - if, 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

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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.*

Conversion

If your coverage terminates for one of the reasons described below, you may apply for conversion coverage without furnishing evidence of insurability.

Reasons for termination:

- You cease to be eligible as a Participant or Enrolled Dependent.
- Continuation coverage ends.

This right to conversion coverage is contingent upon the exhaustion of COBRA continuation coverage.

See also Continuation of Coverage and Conversion section above.

Application and payment of the initial payment must be made to our designated carrier within 31 days after coverage ends under this Plan. Conversion coverage will be issued in accordance with the terms and conditions the designated carrier has in effect at the time of application. Conversion coverage may be substantially different from coverage provided under this Plan.

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

Relationship with Providers

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

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

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

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

We 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 payment of Benefits.
- Notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

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

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

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

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Incentives to You

Sometimes the Claims Administrator may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact the Claims Administrator if you have any questions.

Interpretation of Benefits

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

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this 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

Plan Amendments and Riders are effective on the date specified.

Any provision of the Plan which, on its effective date, is in conflict with the requirements of federal statutes or regulations, or applicable state law provisions (of the jurisdiction in which the Plan is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

Any change or amendment to or termination of the Plan, its benefits or its terms and conditions, in whole or in part, shall be made solely in a written amendment (in the case of a change or amendment) or in a written resolution (in the case of a termination), whether prospective or retroactive, to the Plan, in accordance with the procedures established by us. Covered Persons will receive notice of any material modification to the Plan. No one has the authority to make any oral modification to the SPD.

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to Benefits. These errors include, but are not limited to,

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providing misinformation on eligibility or Benefit coverages or entitlements. It is your responsibility to confirm the accuracy of statements made by us or our designees, including the Claims Administrator, in accordance with the terms of this SPD and other Plan documents.

Information and Records

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

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

We and the Claims Administrator have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Plan, we, the Claims Administrator, and our related entities may use and transfer the information gathered under the Plan for research and analytic purposes.

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

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

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

Examination of Covered Persons

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

Workers' Compensation not Affected

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

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

Medicare Eligibility

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

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

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

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

Subrogation and Reimbursement

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

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Right to Subrogation

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

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

Right to Reimbursement

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

Third Parties

The following persons and entities are considered third parties:

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

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— 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.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- The Plan may enforce its subrogation and reimbursement rights regardless of whether you have been "made whole" (fully compensated for your injuries and damages).
- You will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:

  — Complying with the terms of this section.

  — Providing any relevant information requested.

  — Signing and/or delivering documents at its request.

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

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  — 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.
- You will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a Sickness or Injury caused by a third party.
- The Plan's rights will not be reduced due to your own negligence.
- The Plan may file suit in your name and take appropriate action to assert its rights under this section. The Plan is not required to pay you part of any recovery it may obtain from a third party, even if it files suit in your name.
- The provisions of this section apply to the parents, guardian, or other representative of an Enrolled Dependent child who incurs a Sickness or Injury caused by a third party.
- In case of your wrongful death, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs.

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- 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.

Refund of Overpayments

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

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

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

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

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Limitation of Action

You cannot bring any legal action against us to recover reimbursement prior to the expiration of sixty days after a request for benefits has been filed, and no such action can be brought at all unless brought within three years from the expiration of time to submit a request for benefits.

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Section 10: Glossary of Defined Terms

This section:

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

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

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

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

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

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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 Program – 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.

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

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

Common Law Spouse – your spouse by common law of the opposite sex is eligible to enroll for coverage under this Plan if you and your Common Law Spouse complete and sign our Affidavit of Common Law Marriage and we receive the necessary proof, as determined by us.

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.

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

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 abuse, or their symptoms.

A Covered Health Service is a health care service or supply described in Section 1: What's Covered--Benefits as a Covered Health Service, which is not excluded under Section 2: What's Not Covered--Exclusions. If a service or category of service is not listed as covered, it is not covered under this plan. All other services are non-covered (excluded).

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 an unmarried dependent child of the Participant or the Participant's spouse. Only

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one of the following persons can be eligible to enroll under family coverage with you at the same time.

- Spouse: Your lawful spouse, according to the statutes of the state in which you were married, is eligible to enroll for coverage under this plan.
- Former Spouse: In the event of a divorce, your former spouse will continue to be eligible for coverage provided that your divorce decree requires you to maintain continuing coverage under a family policy in accordance with state law. In that case, your former spouse will remain eligible on your policy until the earlier of the date either you or your former spouse are remarried, or until your former spouse has comparable coverage available through his or her own employment.
- Common Law Spouse: Your spouse by common law of the opposite gender is eligible to enroll for coverage under this plan if you and your Common Law Spouse complete and sign our Affidavit of Common Law Marriage and we receive the necessary proof, as determined by us.
- Domestic Partner: Your domestic partner, as defined under Rhode Island law, is eligible to enroll for coverage under this plan if you complete and sign the Plan Administrator's Affidavit of Domestic Partnership.

The term child includes any of the following children of the Participant:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.

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- A child for whom legal guardianship has been awarded to the Participant or the Participant's spouse.
- A foster child permanently living with an eligible Participant.

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. The Enrolling Group is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order (QMCSO).

You must provide satisfactory proof as determined by the Plan Administrator to enroll your adopted children, step-children, foster children, or children who will be considered eligible due to a QMCSO.

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

- A Dependent includes any unmarried dependent child to the end of the calendar year in which they reach 19 years of age. If a child is married before his or her 19th birthday he or she will not be covered and not be considered eligible starting on the first day of the month following the marriage.
- A Dependent includes an unmarried dependent child who is 19 years of age or older, but less than 25 years of age only if you furnish evidence upon our request, satisfactory to us, of all the following conditions:
  - The child must be an Eligible Student and,
  - The child must receive over one-half of his/her financial support from the Participant.
- A Dependent includes any unmarried dependent child of any age who is medically certified as disabled and is unable to support himself or herself because of such disability, provided however,

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that the child is chiefly dependent upon the Participant for support and care because of a mental impairment or physical disability which can be expected to result in death or can be expected to last for a continuous period of not less than 12 months. If an eligible retiree has a disabled child, he or she must fill out a special application. In the application, the eligible retiree must show proof of the child's disability. We may require that a Physician chosen by us examine the child. We will pay for that examination. We may continue to ask for and you will be required to submit proof that the child continues to meet these conditions of disability and dependency. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

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.

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

Durable Medical Equipment - medical equipment (and supplies necessary for the effective use of equipment) that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is primarily and customarily used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.

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- 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:

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

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

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

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

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

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

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Eligible Person - a retired full-time employee of the Plan Sponsor who was scheduled to work at his or her job at least 20 hours per week. Contact the Plan Sponsor for more information on eligibility.

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

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

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

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

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

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use, except that coverage is provided for a drug which has been prescribed for treatment of cancer even if the drug has not been approved by the FDA for that indication, if the drug is recognized for the treatment of that indication:

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- In one of the following established reference compendia: (1) The U.S. Pharmacopoeia Drug Information Guide for the Health Care Professional (USPDI); (2) The American Medical Association's Drug Evaluations (AMADE); or (3) The American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information (AHES-DI).
- In published scientific studies published in any peer-reviewed national professional journal.

However, there is no coverage for any drug when the FDA has determined its use to be contraindicated.

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 trials set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Except as set forth in Section 1: What's Covered – Benefits; 2. Cancer Therapies – Investigational and 17. Lyme Disease, 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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Eligible Student - a person who is enrolled in and attending at least two courses or four credits per semester in a recognized course of study or training at one of the following educational institutions offering curricula in excess of six months per year.

- An accredited high school.
- An accredited academic college or university.
- A licensed vocational school, technical school, beautician school, automotive school or similar training school.
- The program of study in which your child is enrolled must lead to a certificate, diploma, degree, or other recognized evidence of completion.

You are no longer an Eligible Student at the end of the calendar year during which you graduate or otherwise cease to be enrolled and in attendance at the institution.

You continue to be an Eligible Student during periods of regular vacation established by the institution. If you do not continue as an Eligible Student immediately following the period of vacation, the Eligible Student designation will end as described above. You will be required to recertify annually that your child continues to be a student.

Home Health Care Agency - a program or organization authorized by law to provide health care services in the home, including medically necessary programs to reduce the length of a hospital stay or to eliminate or delay a hospital admission.

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

- Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.

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- Has 24 hour nursing services.
- Either listed as a hospital by the American Hospital Association or accredited by JCAHO (Joint Commission on Accreditation of Health Care Organizations).

A Hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home, convalescent home institution, rest home, nursing home, school/college infirmary, halfway house or residential facility, long-term care facility, free-standing emergency medical center or free-standing ambulatory surgi-center, facility providing primarily custodial, educational, or rehabilitative care, or sections of hospitals used for these purposes.

- A General Hospital means a Hospital which is designed to care for medical and surgical patients with acute illness or injury.
- A Specialty Hospital means a Hospital or the specialty unit of a General Hospital which is licensed by the State and designed to care for patients with injuries or special illnesses, including but not limited to a mental health rehabilitation unit or hospital.

Hospital Services - are the following in-hospital services:

- Anesthesia supplies;
- Blood services including: administration, typing, cross matching, drawing maintenance of donor room, and charges for plasma and derivatives. Charges for whole blood, red blood cells and blood replacement costs and penalty fees are NOT covered;
- Cardiac pacemakers;
- Chemotherapy and radiation (Note: coverage of high dose chemotherapy and/or radiation services related to autologous bone marrow transplantation is limited.

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- Computerized axial tomography (CAT or CT scan) and magnetic resonance imaging (MRI).
- Diagnostic X-rays, radiotherapy and diagnostic and therapeutic radioisotopic services;
- Drugs and medications as currently listed in the National Formulary or the U.S. Pharmacopeia;
- Electrocardiograms (EKGs) and electro-encephalogram (EEG);
- General nursing care; AND
- Hearing evaluation;
- Hemodialysis – use of machine and other physical equipment;
- Inhalation and oxygen therapy;
- Insulin and shock therapy;
- Laboratory examinations and pulmonary function tests;
- Mammogram;
- Meals and other dietary services;
- Medical and surgical supplies;
- Durable medical equipment;
- Occupational therapy;
- Original prosthetic and initial prosthesis when provided and billed for by the hospital where you are an inpatient or the hospital where you return within a reasonable period of time for an initial prosthesis or original prosthetic, providing the prosthesis or the prosthetic is related to the original hospital stay;
- Pap smear;
- Physical therapy;
- Respiratory therapy services;

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- Recovery room;
- Room accommodations in a ward or semi-private room;
- Services performed in intensive care units;
- Services of a licensed clinical psychologist when ordered by a doctor and billed by a hospital;
- Speech evaluation and therapy;
- Ultrasonography (ultrasounds);
- Use of the operating room;
- Other hospital services necessary for your treatment which we have approved.

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.

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

Medical Supplies - those consumable supplies which are disposable and not intended for reuse. These supplies are ordered by a physician and are essential for the care or treatment of an illness, injury or congenital defect.

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

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses.

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

Mental Illness - any mental disorder and substance abuse disorder that is listed in the most recent revised publication or the most updated volume of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICO) published by the World Health Organization and that substantially limits the life activities of the person with the illness; provided that tobacco and caffeine are excluded from the definition of "substance" for the purposes of this definition. "Mental illness" shall not include: (i) mental retardation, (ii) learning disorders, (iii) motor skills disorders, (iv) communication disorders, and (v) mental disorders classified as "V" codes.

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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.

A provider may enter into an agreement 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 products included in the participation agreement, and a non-Network provider for other 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. Network Benefits include Emergency Health Services.

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 Copayments you pay every calendar year. Once you reach Out-of-Pocket Maximum for Non-Network Benefits, Benefits for those Covered

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Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that calendar year.

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

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

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

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

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

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- 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.

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 marriage and family therapist, mental health counselor, midwife, nurse anesthetist, nurse first assistant, nurse practitioner 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 – Early Retiree PPO Plan for State of Rhode Island Health Benefit Plan.

Plan Administrator - is State of Rhode Island or its designee.

Plan Sponsor - State of Rhode Island. References to "we", "us", and "our" throughout the SPD refer to the Plan Sponsor.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.

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- Childbirth.
- Any complications associated with Pregnancy.

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.

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

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

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

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

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.)

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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.

Except as set forth in Section 1: What's Covered – Benefits; 2. Cancer Therapies – Investigational and 17. Lyme Disease, if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we and the Claims Administrator may, in our discretion, determine that an Unproven Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we and the Claims Administrator must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

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

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Riders, Amendments, Notices

Outpatient Prescription Drug Rider

Attachment I

Early Retiree PPO Plan

Outpatient Prescription Drug Rider

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Outpatient Prescription Drug Rider

This Rider to the Summary Plan Document provides Benefits for outpatient Prescription Drug Products.

Benefits are provided for outpatient Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy.

Because this Rider is part of 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 of the Summary Plan Document and in Section 3: Glossary of Defined Terms of this Rider.

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When we use the words "we," "us," and "our" in this document, we are referring to 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 the Summary Plan Document Section 10: Glossary of Defined Terms.

NOTE: The Coordination of Benefits provision Section 7: Coordination of Benefits in the Summary Plan Document does not apply to Prescription Drug Products covered through this Rider. Prescription Drug Product Benefits will not be coordinated with those of any other health coverage plan.

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Introduction

Benefits for Outpatient Prescription Drug Products

Benefits are available for Outpatient Prescription Drug Products on the Prescription Drug List at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments or other payments that vary depending on which of the three tiers of the Prescription Drug List the Outpatient Prescription Drug is listed.

Some drugs are not on the Prescription Drug List. Only drugs on the Prescription Drug List are covered benefits under this plan. The Prescription Drug List is subject to change upon review.

NOTE: Covered injectable drugs obtained at a pharmacy for self-injection are subject to the standard pharmacy copayments.

Coverage Policies and Guidelines

The Claims Administrator's Prescription Drug List ("PDL") Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost

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including, but not limited to, available rebates, and assessments on the cost effectiveness of the Prescription Drug Product.

The Claims Administrator may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access www.myuhc.com through the Internet, or call the Customer Service number on your ID card for the most up-to-date tier status.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified during regular business hours.

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You may seek reimbursement from us as described in the Summary Plan Document Section 5: How to File a Claim. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment and any deductible that applies.

Coupons, Incentives and Other Communications

At various times, we or the Claims Administrator may send mailings to you or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you, at your discretion, to purchase the described drug product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

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Section 1: What's Covered--Prescription Drug Benefits

We provide Benefits under the Plan for outpatient Prescription Drug Products:

- Designated as covered at the time the Prescription Order or Refill is dispensed when obtained from a Network or non-Network Pharmacy.
- Refer to exclusions in your Summary Plan Document Section 2: What's Not Covered--Exclusions and as listed in Section 2 of this Rider.

Benefits for Outpatient Prescription Drug Products

Benefits for outpatient Prescription Drug Products are available when the outpatient Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception and is approved by the F.D.A.

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

When a Brand-name Drug Becomes Available as a Generic

When a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment may change. You will pay the Copayment applicable for the tier to which the Prescription Drug Product is assigned.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description of Pharmacy Type and Supply Limits" column of the Benefit Information table.

Note: Some products are subject to additional supply limits based on criteria that the Claims Administrator has developed, subject to its periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

You may determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing through the Internet at www.myuhc.com or by calling Customer Service at the telephone number on your ID card.

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What You Must Pay

You are responsible for paying the applicable Copayment described in the Benefit Information table when Prescription Drug Products are obtained from a retail or home delivery pharmacy.

The amount you pay for any of the following under this Rider will not be included in calculating **any Out-of-Pocket Maximum stated in your Summary Plan Document**:

- Copayments for Prescription Drug Products.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Cost) will not be available to you.

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Benefit Information

Description of Pharmacy Type and Supply Limits	Your Copayment Amount

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for outpatient Prescription Drug Products dispensed by a retail Network Pharmacy. The following supply limits apply:

20% of the Prescription Drug Cost

- As written by the provider, up to a consecutive 34-day supply of a non-maintenance Prescription Drug Product or up to a consecutive 60-day supply or 100 units (whichever is greater) of a maintenance Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

- 1 Nicotine Transdermal Patch or Nicotine Chewing Gum per lifetime. You must pay in full for a Nicotine Transdermal Patch or Nicotine Chewing Gum prescription at the time the prescription is dispensed. In order to receive reimbursement, submit a claim to us along with written certification from your Physician that you have been smoke-free for one year. Reimbursement will be based on our allowance, less your applicable copayment.

No Copayment applies to Oral Cancer Agents prescribed for cancer treatment.

Prescription Drugs from a Retail Non-Network Pharmacy

Benefits are provided for outpatient Prescription Drug Products dispensed by a retail non-Network Pharmacy.

If the Prescription Drug Product is dispensed by a retail non-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with us, as described in your Summary Plan Document of Coverage. We will not reimburse you for the difference between the Predominant Reimbursement Rate and the non-Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from a non-Network Pharmacy.

The following supply limits apply:

- As written by the provider, up to a consecutive 34-day supply of a non-maintenance Prescription Drug Product or up to a consecutive 60-day supply or 100 units (whichever is greater) of a maintenance Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

Your Benefit includes smoking cessation treatment, including the use of an Over-the-Counter (OTC) or prescription FDA approved nicotine replacement therapy, when prescribed by a provider.

20% of the Predominant Reimbursement Rate

*Out-of-pocket amounts on this benefit will not accumulate to the annual maximum out-of-pocket expense. This benefit level will not increase due to having satisfied the annual maximum out-of-pocket expense through other benefits

Description of Pharmacy Type and Supply Limits	Your Copayment Amount
• 1 Nicotine Transdermal Patch or Nicotine Chewing Gum per lifetime. You must pay in full for a Nicotine Transdermal Patch or Nicotine Chewing Gum prescription at the time the prescription is dispensed. In order to receive reimbursement, submit a claim to us along with written certification from your Physician that you have been smoke-free for one year. Reimbursement will be based on our allowance, less your applicable copayment.	

Prescription Drug Products from a Home Delivery Network Pharmacy

Description of Pharmacy Type and Supply Limits	Your Copayment Amount
Benefits are provided for outpatient Prescription Drug Products dispensed by a home delivery Network Pharmacy. The following supply limits apply: • As written by the provider, up to a consecutive 102-day supply of a non-maintenance Prescription Drug Product or up to a consecutive 180-day supply of a maintenance Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • 1 Nicotine Transdermal Patch or Nicotine Chewing Gum per lifetime. You must pay in full for a Nicotine Transdermal Patch or Nicotine Chewing Gum prescription at the time the prescription is dispensed. In order to receive reimbursement, submit a claim to us along with written certification from your Physician that you have been smoke-free for one year. Reimbursement will be based on our allowance, less your applicable copayment. No Copayment applies to Oral Cancer Agents. Note that prescription drug products from a Home Delivery Non-Network Pharmacy are not covered.	20% of the Prescription Drug Cost

Section 2: What's Not Covered--Exclusions

Exclusions from coverage listed in the Summary Plan Document apply also to this Rider. In addition, the following exclusions apply:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
3. Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.
4. Except as specifically provided in your Summary Plan Document under "Section 1: Cancer Therapies Investigational and Lyme Disease, and as specifically provided in the definition of "Prescription Drug Product" in Section 3 of this document, Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Claims Administrator to be experimental, investigational or unproven.
5. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare)

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whether or not payment or benefits are received, except as otherwise provided by law.

6. Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
7. Any product dispensed for the purpose of appetite suppression and other weight loss products.
8. A specialty medication Prescription Drug Product (including, but not limited to, immunizations and allergy serum) which, due to its characteristics as determined by the Claims Administrator, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception. Biological products for allergy immunization are not covered.
9. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered. Needles and syringes are not covered except for use with insulin.
10. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
11. Unit dose packaging of Prescription Drug Products.
12. Medications used for cosmetic purposes.
13. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that are determined to not be a Covered Health Service.

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14. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
15. Over-the-Counter Drugs, other than Smoking Cessation drugs as provided in (Section 1: What's Covered-Description of Covered Health Service).
16. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug. Prescription Drug Products that are comprised of components that are available in over-the-counter form or equivalent.
17. New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by the Claims Administrator's Prescription Drug List Management Committee.
18. Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill.
19. Any Prescription Drug Product that is considered to be life-style enhancing such as drugs prescribed to treat sexual dysfunction.
20. The prescription drug, RU-486, or its therapeutic equivalent.
21. Drugs dispensed in violation of state or federal law.
22. Prescription drugs prescribed or dispensed outside of the dispensing guidelines of the Claims Administrator.
23. Drugs that have not proven effective according to the Federal Food and Drug Administration.
24. Blood fractions

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Section 3: Glossary of Defined Terms

This section:

- Defines the terms used throughout this Rider. Other defined terms used throughout this Rider can be found in Section 10: Glossary of Defined Terms of your Summary Plan Document.
- Is not intended to describe Benefits.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the Claims Administrator identifies as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by the Claims Administrator.

Designated Pharmacy - a pharmacy that has entered into an agreement on behalf of the pharmacy with the Claims Administrator or with an organization contracting on its behalf, to provide specific Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

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Generic - a Prescription Drug Product: (1) that is chemically equivalent to a Brand-name drug; or (2) that the Claims Administrator identifies as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by the Claims Administrator.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with the Claims Administrator or its designee to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by the Claims Administrator as a Network Pharmacy.

A Network Pharmacy can be either a retail or a home delivery pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the FDA, and ending on the earlier of the following dates:

- The date it is assigned to a tier by the Claims Administrator's Prescription Drug List Management Committee.
- December 31st of the following calendar year.

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Predominant Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and sales tax. The Predominant Reimbursement Rate is calculated using the Prescription Drug Cost that applies for that particular Prescription Drug Product at most Network Pharmacies.

Prescription Drug Cost - the rate we have agreed to pay Network Pharmacies, including a dispensing fee and any sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List - a list that identifies those Prescription Drug Products for which Benefits are available under this Rider. This list is subject to periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.myuhc.com or by calling the Customer Service number on your ID card.

Prescription Drug List Management Committee - the committee that the Claims Administrator designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Plan, this definition includes:

- Inhalers (with spacers).

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- Insulin.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices;
  - glucose monitors.
- In accordance with the provisions in R.I. Gen. Laws Section 27-55-1, prescription drugs used for the treatment of cancer, even if the drug has not been approved by the FDA for that indication, provided that the drug is recognized for treatment of that indication in one standard reference compendia, or in the medical literature.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties.

- End of Outpatient Prescription Drug Rider -

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Attachment I

Women's Health and Cancer Rights Act of 1998

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

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

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

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

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

Group health plans and health insurance issuers generally may not, under federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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