

Summary Plan Description

Franklin County Board of Commissioners

Choice Plus Health Benefit Plan
for Pickaway County Employees

Group Number: 706656
Effective Date: January 1, 2006

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Introduction

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

How to Use this Document

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

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

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

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

To continue reading, go to right column on this page

Information about Defined Terms

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

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

Your Contribution to the Benefit Costs

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

Customer Service and Claims Submittal

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

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

Prior Notification: As shown on your ID card.

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

Claims Submittal Address:

United HealthCare Insurance Company

P. O. Box 981502

El Paso, Texas 79998-1502

Requests for Review of Denied Claims and Notice of Complaints:

Name and Address For Submitting Requests:

United HealthCare Insurance Company

Appeals

P. O. Box 659773

San Antonio, Texas 78265-9773

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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.

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.

Copayment

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

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Eligible Expenses

Eligible Expenses are the amount that we will pay for Benefits as determined by us or by our designee. In almost all cases our designee is the Claims Administrator. For a complete definition of Eligible Expenses that describes how payment is determined, see (Section 10: Glossary of Defined Terms).

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

For Network Benefits, you are not responsible for any difference between the Eligible Expenses and the amount the provider bills, unless you agreed to reimburse the provider for such services. For 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.

Notification Requirements

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

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

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

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

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

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

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Payment Information

Payment Term	Description	Amounts
Annual Deductible	<p>The amount you pay for Covered Health Services before you are eligible to receive Non-Network Benefits. For a complete definition of Annual Deductible, see (Section 10: Glossary of Defined Terms).</p> <p>Any amount you pay for medical expenses in the last three months of the previous calendar year, that is applied to the previous Annual Deductible, will be carried over and applied to the current Annual Deductible. This carry-over feature applies only to the individual Annual Deductible.</p>	<p><u>Network</u></p> <p>No Annual Deductible</p>
		<p><u>Non-Network</u></p> <p>\$200 per Covered Person per calendar year, not to exceed \$500 for all Covered Persons in a family.</p>
Out-of-Pocket Maximum	<p>The maximum you pay, out of your pocket, in a calendar year for Copayments. For a complete definition of Out-of-Pocket Maximum, see (Section 10: Glossary of Defined Terms).</p>	<p><u>Network</u></p> <p>\$500 per Covered Person per calendar year, not to exceed \$1,250 for all Covered Persons in a family.</p>
		<p><u>Non-Network</u></p> <p>\$800 per Covered Person per calendar year, not to exceed \$2,000 for all Covered Persons in a family.</p> <p>Out-of-Pocket Maximum includes the Annual Deductible.</p>

Benefit Information

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>1. Allergy Injections Benefits for allergy immunotherapy injections received in a Physician's office.</p>	<p><u>Network</u> No</p>	<p>\$10 per visit</p>	<p>No</p>	<p>No</p>
	<p><u>Non-Network</u> No</p>	<p>20%</p>	<p>Yes</p>	<p>Yes</p>
<p>2. Ambulance Services Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed. Non-Emergency ambulance transportation is not covered.</p>	<p><u>Network</u> No</p>	<p><i>Ground Transportation:</i> No Copayment <i>Air Transportation:</i> No Copayment</p>	<p>No</p>	<p>No</p>
	<p><u>Non-Network</u> No</p>	<p>Same as Network</p>	<p>Same as Network</p>	<p>Same as Network</p>

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<h3>3. Dental – Hospital or Outpatient Surgery Services</h3> <p>Hospital or outpatient surgery center charges provided in conjunction with dental care, including anesthetics, if a dentist and a Physician determine that hospitalization or general anesthesia is required for dental care because:</p> <ul style="list-style-type: none"> • The Covered Person is a child under the age of 5; or • The Covered Person has a chronic disability that prevents effective treatment in a dental office; or • The Covered Person has a medical condition that prevents effective treatment in a dental office. <p>Coverage does not include expenses for the diagnosis and treatment of dental disease.</p> <p style="text-align: center;">Notify the Claims Administrator</p> <p>Please remember that for Non-Network Benefits you must notify the Claims Administrator five business days before receiving services.</p>	<u>Network</u> No	No Copayment	No	No
	<u>Non-Network</u> Yes	20%	Yes	Yes
<h3>4. Dental Services - Accident only</h3> <p>Services performed by a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D." for the treatment of any sound natural teeth made necessary as a result of an Injury (except for an Injury resulting from biting or chewing). No Coverage is provided unless the dentist certifies that teeth were sound natural</p>	<u>Network</u> No	No Copayment	No	No

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>teeth, which were injured as a result of an accident. (A sound natural tooth 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.)</p> <p>Services must be provided and completed within 6 months of the Injury.</p> <p style="text-align: center;">Notify the Claims Administrator</p> <p>Please remember that for Non-Network Benefits you must notify the Claims Administrator as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. (You do not have to provide notification before the initial Emergency treatment.)</p>	<u>Non-Network</u> Yes	20%	Yes	Yes
<p>5. Durable Medical Equipment</p> <p>Durable Medical Equipment that meets each of the following criteria:</p>	<u>Network</u> No	No Copayment	No	No
<ul style="list-style-type: none"> • Can withstand repeated use and is not consumable or disposable. • Used to serve a medical purpose. • Generally not useful to a person in the absence of Sickness or Injury. • Appropriate for use in the home. <p>If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment.</p>	<u>Non-Network</u> Yes, for items more than \$1,000	20%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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Examples of Durable Medical Equipment include, **but are not limited to:**

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks.)
- Delivery pumps for tube feedings (including tubing and connectors.)
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part are considered Durable Medical Equipment and are a Covered Health Service.
- 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.)

We provide Benefits only for a single purchase (including repair/ replacement) of a type of Durable Medical Equipment once every three calendar years.

We and the Claims Administrator will decide if the equipment should be purchased or rented.

Notify the Claims Administrator

Please remember that for Non-Network Benefits you must notify the Claims Administrator before obtaining any single item of

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Durable Medical Equipment that costs more than \$1,000 (either purchase price or cumulative rental of a single item).				
6. Emergency Health Services				
Emergency Health Services for the stabilization or initiation of treatment of Emergency conditions provided on an outpatient basis at either a Hospital or an Alternate Facility.	<u>Network</u> No	\$50 per occurrence	No	No
The Copayment will be waived if you are admitted directly to hospital or Skilled Nursing Facility from emergency room. The Copayment WILL NOT BE WAIVED if you have been placed in an observation bed for the purpose of monitoring your condition, rather than being admitted as an inpatient in the Hospital.		\$100 per occurrence for non-Emergency Health Services obtained in an Emergency Room.		
You will find more information about Benefits for Emergency Health Services in (Section 3: Description of Network and Non-Network Benefits).	<u>Non-Network</u> No	Same as Network	Same as Network	Same as Network
7. Eye Examinations				
Eye examinations received from a Physician in the Physician's office.	<u>Network</u> No	\$10 per visit	No	No
Benefits include one routine vision exam, including refraction, to detect vision impairment by a Network provider each calendar year. Benefits for the diagnosis and treatment of a Sickness or Injury are not limited.				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.	<u>Non-Network</u> No	20% for Sickness or Injury only	Yes	Yes
8. Home Health Care	<u>Network</u>	No Copayment	No	No
Services received from a Home Health Agency that are both of the following:	No	No Copayment	No	No
<ul style="list-style-type: none"> Ordered by a Physician. Provided by or supervised by a registered nurse in your home. 	<u>Non-Network</u> Yes	Same as Network	Same as Network	Same as Network
Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required.	<u>Non-Network</u> Yes	Same as Network	Same as Network	Same as Network
Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:	<u>Non-Network</u> Yes	Same as Network	Same as Network	Same as Network
<ul style="list-style-type: none"> It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient. It is ordered by a Physician. It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair. It requires clinical training in order to be delivered safely and 	<u>Non-Network</u> Yes	Same as Network	Same as Network	Same as Network

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

- It is not Custodial Care.

We and the Claims Administrator will decide if skilled care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Any combination of Network and Non-Network Benefits is limited to 120 visits per calendar year.

Notify the Claims Administrator

Please remember that for Non-Network Benefits you must notify the Claims Administrator five business days before receiving services.

9. Hospice Care

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

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

<u>Network</u> No	No Copayment	No	No
<u>Non-Network</u> Yes	Same as Network	Same as Network	Same as Network

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Notify the Claims Administrator				
Please remember that for Non-Network Benefits, you must notify the Claims Administrator five business days before receiving services.				
<hr/> 10. Hospital - Inpatient Stay				
Confinement, services and supplies provided in a Hospital on a semi-private accommodations basis (a room with two or more beds).	<u>Network</u> No	No Copayment	No	No
Notify the Claims Administrator				
Please remember that for Non-Network Benefits you must notify the Claims Administrator as follows:				
<ul style="list-style-type: none"> • For elective admissions: five business days before admission. • For non-elective admissions: within one business day or the same day of admission. 	<u>Non-Network</u> Yes	20%	Yes	Yes
If you don't notify the Claims Administrator, you will be responsible for payment of the first \$300 of Eligible Expenses.				
<hr/> 11. Infertility Services				
Services for the diagnosis and treatment of infertility when provided by or under the direction of a Network Physician in the Physician's office, a Hospital or Alternate Facility.	<u>Network</u> No	50%	Yes	No
The following reproductive services are excluded:				
<ul style="list-style-type: none"> • Artificial insemination. 				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> In vitro fertilization. Gamete intrafallopian transfer (GIFT) procedures. Zygote intrafallopian transfer (ZIFT) procedures. Embryo transport. Donor ovum and semen and related costs including collection and preparation. Experimental, Investigational or Unproven Services for the treatment of infertility. 	<p><u>Non-Network</u> Non-Network Benefits are not a Covered Health Service.</p>	<p>Non-Network Benefits are not a Covered Health Service.</p>	<p>Non-Network Benefits are not a Covered Health Service.</p>	<p>Non-Network Benefits are not a Covered Health Service.</p>

12. Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

There are special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify the Claims Administrator during the first trimester.

Coverage is provided 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.

Network
No

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

No Copayment applies to Physician office visits for prenatal care after the first visit.

Non-Network
Yes, if Inpatient Stay exceeds time frames

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

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. If discharge occurs earlier than these specific time periods, the Plan shall provide coverage for post-discharge care, which shall consist of a minimum of two visits, at least one of which shall be in the home. Post-discharge visits shall be conducted by a registered professional nurse with experience in maternal and child health nursing.

Notify the Claims Administrator

Please remember that for Non-Network Benefits, you must notify the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described.

13. Medical Supplies

Outpatient medical supplies for the treatment of Sickness or Injury when such supplies are used to serve a medical purpose. Benefits include, but are not limited to: ostomy supplies, surgical dressings, catheters, splints, diabetic supplies such as syringes, needles, lancets, alcohol swabs, and glucose test strips, Aerochambers, Inspirease and Breathancers. Benefits for ostomy supplies include only the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and catheters.
- Skin barriers.

<u>Network</u> No	No Copayment	No	No
<u>Non-Network</u> No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<hr/>				
14. Nutrition Education	<u>Network</u>	No Copayment	No	No
Health Services provided on an outpatient basis for nutrition education for a Covered Person with diabetes.	No			
	<u>Non-Network</u>	20%	Yes	Yes
	No			
<hr/>				
15. Outpatient Surgery, Diagnostic and Therapeutic Services	<u>Network</u>	No Copayment	No	No
Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:	No			
<ul style="list-style-type: none"> • Surgery and related services. • Lab and radiology/X-ray. • Cytologic screening. • Mammography screening, subject to the following limits: <ul style="list-style-type: none"> — One screening during the period of time a woman is 35-39 years of age. — One screening per calendar year for women 40 years of age or older. • Other diagnostic tests and therapeutic treatments (including cancer chemotherapy or intravenous infusion therapy). 	<u>Non-Network</u>	20% Benefits for mammography screening are limited to \$85 per screening.	Yes	Yes
	Yes, for Outpatient Surgery			

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient surgery, diagnostic and therapeutic services are described under *Professional Fees for Surgical and Medical Services* below.

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

Notify the Claims Administrator

Please remember that for Non-Network Benefits for Outpatient Surgery, you must notify the Claims Administrator five business days before receiving services.

16. Physician's Office Services

Covered Health Services received in a Physician's office including:

- Treatment of a Sickness or Injury.
- Preventive medical care.
- Voluntary family planning.
- Well-baby and well-child care.
- Routine physical examinations.
- Hearing examinations (Routine hearing screenings must be provided by a Network Physician.) (For vision exams, see *Eye Examinations* earlier in this section.)
- Immunizations.

Network
No

\$10 per visit

No

No

Non-Network
No

20%
Benefits for mammography screening are limited to \$85 per screening.

Yes

Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> • Cytologic screening. • Mammography screening, subject to the following limits: <ul style="list-style-type: none"> — One screening during the period of time a woman is 35-39 years of age. — One screening per calendar year for women 40 years of age or older. <p>Non-Network Benefits for annual physical examinations for adults are limited to \$150 per calendar year. Non-Network Benefits for child health supervision are limited as follows:</p> <ul style="list-style-type: none"> • \$500 per Enrolled Dependent child up to age one. • \$150 per calendar year per Enrolled Dependent child from age one to age nine. 				
<h3>17. Professional Fees for Surgical and Medical Services</h3>				
<p>Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility.</p>	<u>Network</u> No	No Copayment	No	No
<p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> above.</p>	<u>Non-Network</u> No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
18. Prosthetic Devices including Foot Orthotics	<u>Network</u> No	No Copayment	No	No
Prosthetic devices that aid body functioning or replace a limb or body part. Benefits include, but are not limited to:	<u>Non-Network</u> Yes	20%	Yes	Yes
<ul style="list-style-type: none"> • Artificial limbs. • Artificial eyes. • First lens(es) following cataract surgery. • The first breast prostheses and two surgical brassieres following a mastectomy; additional breast prostheses as required by the Women's Health and Cancer Rights Act of 1998. • Foot orthotics. 				
If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.				
The prosthetic device or foot orthotic must be ordered by, or provided by or under the direction of, a Physician. Benefits for prosthetic devices or foot orthotics are limited to a single purchase of each type every three calendar years.				
Notify the Claims Administrator				
Please remember that for Non-Network Benefits you must notify the Claims Administrator five business days before receiving services.				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>19. Reconstructive Procedures</p> <p>Services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function.</p>	<p><u>Network</u> No</p>	<p>Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.</p>		
<p>Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.</p>	<p><u>Non-Network</u> Yes</p>	<p>Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.</p>		
<p>Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy related to breast cancer, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact the Claims Administrator at the telephone number on your ID card for more information about Benefits for mastectomy-</p>				

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

Notify the Claims Administrator

Please remember that for Non-Network Benefits you must notify the Claims Administrator five business days before receiving services. When you provide notification, the Claims Administrator can verify that the service is a reconstructive procedure rather than a Cosmetic Procedure. Cosmetic Procedures are always excluded from coverage.

20. Rehabilitation Services – Inpatient Therapy

Rehabilitation therapy services provided on an inpatient basis in a Hospital or Skilled Nursing Facility. Coverage is provided for rehabilitation therapy (physical, occupational and speech) that is expected to result in significant physical improvement in the Covered Person’s condition within a reasonable period of time.

Any combination of Network and Non-Network Benefits is limited to 45 days per calendar year.

Notify the Claims Administrator

Please remember that for Non-Network Benefits you must notify the Claims Administrator as follows:

- For elective admissions: five business days before admission.
- For non-elective admission: within one business day or the same day of admission.

<u>Network</u> No	No Copayment	No	No
<u>Non-Network</u> Yes	20%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<h2>21. Rehabilitation Services - Outpatient Therapy</h2> <p>Short-term outpatient rehabilitation services for:</p> <ul style="list-style-type: none"> • Physical therapy. • Occupational therapy. • Speech therapy. • Pulmonary rehabilitation therapy. • Cardiac rehabilitation therapy. <p>Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician.</p> <p>Benefits are available for rehabilitation services that are expected to result in significant improvement in the Covered Person's condition within a reasonable period of time.</p> <p>Please note that we will pay Benefits for speech therapy only:</p> <ul style="list-style-type: none"> • For restoration after a stroke. • For treatment for a physical abnormality of the larynx. • After a surgery resulting in trauma to anatomical structure affecting speech. • After trauma to anatomical structure affecting speech. • For congenital anomalies affecting speech including cleft palate. 	<p><u>Network</u> No</p>	<p>\$10 per visit for services performed in a Physician's office or alternate outpatient rehabilitation facility</p> <p>No Copayment for services performed in a Hospital</p>	No	No
<p>Please note that we will pay Benefits for speech therapy only:</p> <ul style="list-style-type: none"> • For restoration after a stroke. • For treatment for a physical abnormality of the larynx. • After a surgery resulting in trauma to anatomical structure affecting speech. • After trauma to anatomical structure affecting speech. • For congenital anomalies affecting speech including cleft palate. 	<p><u>Non-Network</u> No</p>	20%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
22. Skilled Nursing Facility/Convalescent Inpatient Facility Services	<u>Network</u> No	No Copayment	No	No
Confinement in a Skilled Nursing Facility or Convalescent Inpatient Facility including semi-private room, related services and other supplies provided for the care and treatment of an Injury or Sickness that would otherwise require Confinement in a Hospital.	<u>Non-Network</u> Yes	No Copayment	No	No
Any combination of Network and Non-Network Benefits is limited to 100 days per calendar year.				
Notify the Claims Administrator				
Please remember that for Non-Network Benefits you must notify the Claims Administrator as follows:				
<ul style="list-style-type: none"> • For elective admissions: five business days before admission. • For non-elective admission: within one business day or the same day of admission. 				
23. Spinal Treatment	<u>Network</u> No	\$10 per visit	No	No
Benefits for Spinal Treatment or chiropractic when provided by a Spinal Treatment provider in the provider's office.	<u>Non-Network</u> No	20%	Yes	Yes
Benefits include diagnosis and related services and are limited to one visit and treatment per day.				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>24. Transplantation Services</p> <p>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:</p> <ul style="list-style-type: none"> • Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. • Heart transplants. • Heart/lung transplants. • Lung transplants. • Kidney transplants. • Kidney/pancreas transplants. • Liver transplants. • Liver/small bowel transplants. • Pancreas transplants. • Small bowel transplants. <p>Benefits are also available for cornea transplants that are provided by a Physician at a Hospital. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive</p>	<p><u>Network</u> No</p>	<p>Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Diagnostic and Therapeutic Services</p>		
	<p><u>Non-Network</u> Non-Network Benefits are not a Covered Health Service.</p>	<p>Non-Network Benefits are not a Covered Health Service.</p>	<p>Non-Network Benefits are not a Covered Health Service.</p>	<p>Non-Network Benefits are not a Covered Health Service.</p>

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Network Benefits.				
Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage.				
Under the Plan there are specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the telephone number on your ID card for information about these guidelines.				
25. Urgent Care Center Services	<u>Network</u> No	\$30 per visit	No	No
Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under <i>Physician's Office Services</i> earlier in this section.	<u>Non-Network</u> No	20%	Yes	Yes
26. Vasectomy and Tubal Ligation Services	<u>Network</u> No	\$50 Copayment for vasectomy services	No	No
Services and supplies for vasectomy and tubal ligation procedures provided in a Physician's office, Alternate Facility or Hospital.	<u>Non-Network</u> No	\$150 Copayment for tubal ligation services.	Yes	Yes

Section 2: What's Not Covered-- Exclusions

This section contains information about:

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

How We Use Headings in this Section

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

We Do not Pay Benefits for Exclusions

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

- It is recommended or prescribed by a Physician.

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- It is the only available treatment for your condition.

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

A. Alternative Treatments

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

B. Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/Barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include **but are not limited to**:
 - Air conditioners.
 - Air purifiers and filters.
 - Batteries and battery chargers.
 - Dehumidifiers.
 - Humidifiers.

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

C. Dental

1. Dental care except as described in (Section 1: What's Covered--Benefits) under the heading *Dental Services - Accident Only*.
2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include **but are not limited to** 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:
 - Dental care described in (Section 1: What's Covered--Benefits) under the heading *Dental/ Anesthesia – Hospital or Outpatient Surgery Services*.
 - Transplant preparation.
 - Initiation of immunosuppressives.
 - The direct treatment of acute traumatic Injury, cancer or cleft palate.
6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.

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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

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

F. Foot Care

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

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G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Prescribed or non-prescribed medical supplies and disposable supplies, except as described in (Section 1: What's Covered--Benefits) under the heading *Medical Supplies*. Excluded supplies include **but are not limited to** items usually stocked in the home for general use such as elastic or adhesive bandages, thermometers or petroleum jelly as well as the following ostomy supplies: gauze, adhesive, adhesive remover, deodorant, pouch covers, or other items not listed in Section 1.
3. Orthotic appliances that straighten or re-shape a body part (including dental braces and some other types of braces), except foot orthotics as provided in (Section 1: What's Covered--Benefits) under the heading *Prosthetic Devices*.
4. Tubings and masks are not covered except when used with Durable Medical Equipment as described in (Section 1: What's Covered--Benefits).

H. Nutrition

1. Megavitamin and nutrition based therapy.
2. Nutritional counseling for either individuals or groups, except as provided for Covered Persons with diabetes as described in (Section 1: What's Covered--Benefits) under the heading *Nutrition Education*.
3. Enteral feedings and other 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 **but are not limited to**:
 - Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
 - Skin abrasion procedures performed as a treatment for acne.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note:** Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in (Section 1: What's Covered--Benefits).
3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
5. Wigs regardless of the reason for the hair loss.

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.

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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.

K. Reproduction

1. Surrogate parenting.
2. The reversal of voluntary sterilization.
3. Health services and associated expenses for therapeutic or elective abortion, except for women in medical danger or for cases of rape or incest reported to a law enforcement agency.
4. Health Services and associated expenses for infertility services except as specifically stated in (Section 1: What's Covered--Benefits) under the heading *Infertility Services*. Excluded treatments and services include:
 - Artificial insemination.
 - In vitro fertilization.
 - Gamete intrafallopian transfer (GIFT) procedures.
 - Zygote intrafallopian transfer (ZIFT) procedures.
 - Embryo transport.
 - Donor ovum and semen and related costs including collection and preparation.

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- Experimental, Investigational or Unproven Services for the treatment of infertility.

L. Services Provided under Another Plan

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

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

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.

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

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 and Hearing

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

P. 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 examinations, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when such services are:
 - For purposes of obtaining, maintaining or otherwise relating to career, education, sports or camp, travel, employment, insurance, marriage or adoption.
 - Related to judicial or administrative proceedings or orders.

— Conducted for purposes of medical research.

— Required to obtain or maintain a license of any type.

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

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13. Custodial Care or care for senile deterioration, mental deficiency or mental retardation.
14. Domiciliary care.
15. Private duty nursing.
16. Respite care.
17. Rest cures.
18. Psychosurgery.
19. Treatment of benign gynecomastia (abnormal breast enlargement in males) if Cosmetic in nature.
20. Medical and surgical treatment of excessive sweating (hyperhidrosis).
21. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
22. Oral appliances for snoring.
23. Speech therapy except as required:
 - For restoration after a stroke.
 - For treatment for a physical abnormality of the larynx.
 - After a surgery resulting in trauma to anatomical structure affecting speech.
 - After trauma to anatomical structure affecting speech.
 - For congenital anomalies affecting speech including cleft palate.
24. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
25. Any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply or equipment.
26. Any charge for services, supplies or equipment advertised by the provider as free.
27. Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency.
28. Any charges prohibited by federal anti-kickback or self-referral statutes.
29. Any additional charges submitted after payment has been made and your account balance is zero.
30. Any outpatient facility charge in excess of payable amounts under Medicare.
31. Any charges by a resident in a teaching hospital where a faculty Physician did not supervise services.

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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 any of the following:

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

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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	Your Network Physician must notify the Claims Administrator for certain Covered Health Services.	You must notify the Claims Administrator for certain Covered Health Services. Failure to notify may result in reduced Benefits. See (Section 1: What's Covered--Benefits), under the <i>Must You Notify the Claims Administrator?</i> column.
Who Should File Claims	Not required. We pay Network providers directly.	You must file claims. See (Section 5: How to File a Claim).

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	Network	Non-Network
Outpatient Emergency Health Services	Emergency Health Services are always paid as a Network Benefit (paid the same whether you are in or out of the Network). That means that if you seek Emergency care at a non-Network facility, you are not required to meet the Annual Deductible or to pay any difference between Eligible Expenses and the amount the provider bills.	

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.

Upon request, 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's Customer Service phone number listed on your ID card or by calling the provider and asking specifically "Are you a network provider for UnitedHealthcare?"

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

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otherwise not available to you, you must choose another Network provider to get Network Benefits.

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

Care CoordinationSM

Your Network Physician is required to notify the Claims Administrator regarding certain proposed or scheduled health services. When your Network Physician notifies the Claims Administrator, they will work together to implement the Care CoordinationSM 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.

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.

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Health Services from Non-Network Providers Paid as Network Benefits

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

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

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.

Your Responsibility for Notification

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

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

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Care CoordinationSM

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

Emergency Health Services

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

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

- If you are confined in a non-Network Hospital after you receive Emergency Health Services, the Claims Administrator must be notified within one business day or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.
- If you are admitted as an inpatient to a Network Hospital within 24 hours of receiving treatment for the same condition as an Emergency Health Service, you will not have to pay the Copayment for Emergency Health Services. The benefit for an Inpatient Stay in a Network Hospital will apply instead.

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Note: Please note that the Copayment for Emergency Health Services **WILL NOT BE WAIVED** if you have been placed in an observation bed for the purpose of monitoring your condition, rather than being admitted as an inpatient in the Hospital.

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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 online enrollment form or **contact their Human Resources Office**. The Plan Administrator or its designee will give the necessary website address or phone numbers to you, along with instructions about submitting your eligibility information and any required contribution for coverage. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

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

You should notify us 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.

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Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Eligible Person	<p>Eligible Person usually refers to an employee of ours who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person and Subscriber, see (Section 10: Glossary of Defined Terms).</p> <p>Except as we have described in this (Section 4: When Coverage Begins), Eligible Persons may not enroll without our permission.</p>	<p>We determine who is eligible to enroll under the Plan.</p>
Dependent	<p>Dependent generally refers to the Subscriber's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a completed definition of Dependent and Enrolled Dependent, see (Section 10: Glossary of Defined Terms).</p> <p>Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan.</p> <p>Except as we have described in this (Section 4: When Coverage Begins), Dependents may not enroll without our permission.</p>	<p>We determine who qualifies as a Dependent.</p>

When to Enroll and When Coverage Begins

When to Enroll	Who Can Enroll	Begin Date
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 first day of the month after 120 days of employment , if the Plan Administrator receives the completed eligibility information within 31 days of the hire date and any required contribution for coverage .
Open Enrollment Period	Eligible Persons may enroll themselves and their Dependents.	The Plan Administrator determines the Open Enrollment Period. Coverage begins at the beginning of the next benefit year or on a date identified by the Plan Administrator if the Plan Administrator receives the completed eligibility information and any required contribution for coverage .
New Eligible Persons	New Eligible Persons, such as a part-time employee becoming full-time , may enroll themselves and their Dependents.	Coverage begins on the first of the next month following the completion of a 120 day waiting period , if the Plan Administrator receives the properly completed eligibility information within 31 days of the date the new Eligible Person becomes eligible to enroll and any required contribution for coverage .

Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.

Except for marriage, coverage begins on the date of the event if the Plan Administrator receives the completed eligibility information within 31 days of the event that makes the new Dependent eligible and any required contribution for coverage.

Coverage for new spouses begins on the first of the next month if the Plan Administrator receives the completed eligibility information within 31 days of the event that makes the new Dependent eligible and any required contribution for coverage.

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.

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 or death).
 - The Eligible Person and/or Dependent cancelled coverage under another plan during the other plan's Open Enrollment.

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 eligibility information and any required contribution within 31 days of the date coverage under the prior plan ended.

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

- The employer stopped paying the contributions.
- In the case of COBRA continuation coverage, the coverage ended.

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.

Filing a Claim for Non-Network Benefits

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us through the Claims Administrator **if the non-Network provider does not file the claim for you**. You must file the claim in a format that

contains all of the information required, as described **under the following heading, "Required Information."**

If there is a question or concern about how a claim was billed by the provider or paid by the Claims Administrator, it is your responsibility to initiate an inquiry regarding the claim within a reasonable timeframe.

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

Required Information

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

- A. 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(s) of service
 - Procedure Code(s) and descriptions of service(s) rendered
 - Charge for each service rendered
 - Provider of service Name, Address and Tax Identification Number
- E. The date the Injury or Sickness began.

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

Payment of Benefits

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

- A. The provider notifies the Claims Administrator that your signature is on file, assigning benefits directly to that provider.
- B. You make a written request for the non-Network provider to be paid directly at the time you submit your claim.

If you provide written permission on a claim form to allow this, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the Subscriber. We will not reimburse third parties who have purchased or been assigned benefits by Physicians or other providers.

Benefit Determinations

Post-Service Claims

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

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

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

Pre-Service Claims

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

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Urgent Claims that Require Immediate Action

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

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

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

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

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

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

Concurrent Care Claims

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

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

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Section 6: Questions, Complaints and Appeals

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

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

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Summary of Recommended Claim Process

Prior to utilizing services, call the Physician, the facility, and/or the ancillary service provider (home care, therapy, laboratory services, imaging/X-ray facility, etc.). Be sure to ask not just whether they accept UnitedHealthcare, but if they are a **Network Provider** for UnitedHealthcare.

Once this is established, determine if there is a copayment and be sure to pay this at the time of the visit (except for emergency room, which will be billed to you usually 2-4 weeks after the visit).

When you receive your Explanation of Benefits (EOB) in the mail, if you do not think the claim was processed correctly, your **first step** is to call UnitedHealthcare Customer Service. The Customer Service number is printed on the back of your UnitedHealthcare ID card.

When calling customer service, be sure you document either on the bill or a piece of paper that you will staple to the EOB:

- A. The date and time you called.
- B. The name of the person you spoke to about the EOB.
- C. The resolution/determination by the Customer Service Representative.

If the Customer Service Representative states that he/she understands the claim was not processed correctly and will resubmit the bill, document this on your EOB and/or the paper stapled to your EOB with your documented information.

If you do not receive a new EOB within three weeks, call UnitedHealthcare Customer Service again and ask for the representative you spoke with on your initial contact.

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When you receive the new EOB, if again it was not processed correctly, you need to contact the Franklin County Benefits office as soon as possible.

If the claim was processed correctly, but was not paid, begin the appeals process. Write a letter stating why you believe the claim should be paid and mail the letter to the appeals process address shown on page 6 of this Summary Plan Description.

You will receive an answer by mail stating if the appeals review committee overturned the denial and will pay the claim or upheld the denial.

For more details on the appeal process, continue reading this section.

If You Are Not Satisfied with a Benefit Determination

If your question or concern is about a benefit determination, you may informally contact Customer Service before requesting a formal appeal. If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in (How to File a Claim) you may appeal it as described below, without first informally contacting Customer Service.

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

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

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How to Appeal a Claim Decision

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

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

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

Appeal Process

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

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Appeals Determinations

Pre-Service and Post-Service Claim Appeals

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

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

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

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

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

For procedures associated with urgent claims, see "Urgent Claim Appeals that Require Immediate Action" below.

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

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

Urgent Claim Appeals that Require Immediate Action

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

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

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

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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.

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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 expenses. A Secondary Coverage Plan pays after the Primary Coverage Plan and may reduce the benefits it pays.

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.
 - a. "Coverage Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical care **portions** of group long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.
 - b. "Coverage Plan" does not include: **non-group medical** insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; benefits for non-medical **portions** 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 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

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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, outpatient prescription drugs, and hearing aids are examples of expenses or services that are not Allowable Expenses under the Plan. The following are additional examples of expenses or services that are not Allowable Expenses:
 - a. If a Covered Person is confined in a private Hospital room, the difference between the cost of a Semi-private Room in the Hospital and the private room, (unless the patient's stay in a private Hospital room is medically necessary in terms of generally accepted medical practice, or one of the Coverage Plans routinely provides coverage for Hospital private rooms) is not an Allowable Expense.
 - b. If a person is covered by two or more Coverage Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.

- c. If a person is covered by two or more Coverage Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
 - d. If a person is covered by one Coverage Plan that calculates its benefits or services on the basis of usual and customary fees and another Coverage Plan that provides its benefits or services on the basis of negotiated fees, the Primary Coverage Plan's payment arrangements shall be the Allowable Expense for all Coverage Plans.
 - e. The amount a benefit is reduced by the Primary Coverage Plan because a Covered Person does not comply with the Coverage Plan provisions. Examples of these provisions are precertification of admissions and preferred provider arrangements.
4. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.
 5. "Closed Panel Plan" is a Coverage Plan that provides health benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
 6. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

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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. **Regardless of benefit design**, 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.**
- 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. **Single Coverage. If you and your spouse have single coverage, then your own Coverage Plan is primary for each of you.**
 - 2. **Non-Dependent or Dependent.** The Coverage Plan that covers the person other than as a dependent, for example as an employee, member, or subscriber is primary and the Coverage Plan that covers the person as a dependent is secondary **in all cases EXCEPT Medicare.**
 - 3. If a person is 65 years of age or older and is an employee, member, subscriber or spouse/dependent, and has a Coverage Plan and Medicare, Medicare is secondary.
 - 4. **Child Covered Under More Than One Coverage Plan.** The order of benefits when a child is covered by more than one Coverage Plan is:

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- a. The Primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:
 - 1) The parents are married;
 - 2) The parents are not separated (whether or not they ever have been married); or
 - 3) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.
- b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or plan years commencing after the Coverage Plan is given notice of the court decree.
- c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
 - 1) The Coverage Plan of the custodial parent;
 - 2) The Coverage Plan of the spouse of the custodial parent;
 - 3) The Coverage Plan of the noncustodial parent; and then
 - 4) The Coverage Plan of the spouse of the noncustodial parent.
- 5. **Active or inactive employee.** The Coverage Plan that covers a person as an employee who is not laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as an employee. If the other

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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 **covered** under the rule labeled D(2).

6. 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, or subscriber (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.
7. Longer or shorter length of coverage. The Coverage Plan that covered the person as an employee, member, or subscriber longer is primary.
8. If a husband or wife is covered under *this* Coverage Plan as a Subscriber and as an Enrolled Dependent, the dependent benefits will be coordinated as if they were provided under another Coverage Plan, this means the Subscriber's benefit will pay first.
9. If the preceding rules do not determine the Primary Coverage Plan, the Allowable Expenses shall be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this provision. In addition, this Coverage Plan will not pay more than it would have paid had it been primary.

Effect on the Benefits of this Plan

- A. When this Coverage Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Coverage Plans

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during a claim determination period are not more than 100 percent of total Allowable Expenses. As each claim is submitted, this Coverage Plan will determine its obligation to pay or provide benefits under its contract.

- 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 (for example, End-Stage Renal Disease or Black Lung).

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.

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- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

Right to Receive and Release Needed Information

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

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

Right of Recovery

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

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Section 8: When Coverage Ends

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

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

General Information about When Coverage Ends

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

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

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

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

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 Master Plan Document is terminated, or with respect to a specific benefit of the Plan, on the date of termination of such benefit. We are responsible for notifying you that your coverage has ended.
You Are No Longer Eligible	Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber or Enrolled Dependent, except that for a spouse after a divorce or legal separation, your coverage ends on that date. Please refer to (Section 10: Glossary of Defined Terms) for a more complete definition of the terms "Eligible Person," "Subscriber," "Dependent," and "Enrolled Dependent."
Subscriber Retires	If a Subscriber is retired or pensioned, coverage ends the last day of the calendar month. We are responsible for providing written notice to the Plan Administrator to end your coverage.

Other Events Ending Your Coverage

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

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

Coverage for a Handicapped Child

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

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

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

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

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

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

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Continuation of Coverage

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

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

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

Continuation Coverage under Federal Law (COBRA)

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

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

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

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- A Subscriber's former spouse.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

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

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 Subscriber's hours of employment.

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

- A. Termination of the Subscriber's employment (for reasons other than the Subscriber's gross misconduct).
- B. Reduction in the Subscriber's hours of employment.
- C. Death of the Subscriber.
- D. Divorce or legal separation of the Subscriber.
- E. Loss of eligibility by an Enrolled Dependent who is a child.
- F. Entitlement of the Subscriber 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 Subscriber and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

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

Notification Requirements for Qualifying Event

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

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

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

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Notification Requirements for Disability Determination or Change in Disability Status

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

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Attachment II to this Summary Plan Description. The contents of the notice must be such that the Plan Administrator is able to determine the covered employee and qualified beneficiary or 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 Subscriber 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 Subscribers 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 Subscribers are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Subscriber qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Subscriber must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Subscriber 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

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

If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at anytime within the first 60 days of continuation coverage for qualifying event A. then the Qualified Beneficiary may elect an additional 11 months of continuation coverage (for a total of 29 months of continued coverage) subject to the following conditions:

- Notice of such disability must be provided within the latest of 60 days after:
 - ◆ the determination of the disability; or
 - ◆ the date of the qualifying event; or
 - ◆ the date the Qualified Beneficiary would lose coverage under the Plan; and
 - ◆ in no event later than the end of the first 18 months.
- The Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months.
- If the Qualified Beneficiary who is entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage.

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

- B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death

of the Subscriber, divorce or legal separation of the Subscriber, 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 Subscribers was entitled to Medicare prior to the qualifying event:
 - Eighteen months from the date of the Subscriber's Medicare entitlement; or
 - Thirty-six months from the date of the Subscriber's Medicare entitlement, if a second qualifying event (that was due to either the Subscriber's termination of employment or the Subscriber'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 Subscriber became entitled to Medicare subsequent to the qualifying event:
 - Thirty-six months from the date of the Subscriber's termination from employment or work hours being reduced (first qualifying event) if:
 - ◆ the Subscriber'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

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limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

- G. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event G.). If the Qualified Beneficiary was entitled to continuation because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event G.) and the retired Subscriber dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for 36 months from the date of the Subscriber's death.
- H. The date the entire Plan ends.
- I. The date coverage would otherwise terminate under the Plan as described in this section under the heading *Events Ending Your Coverage*.

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Section 9: General Legal Provisions

This section provides you with information about:

- General legal provisions concerning your Plan.

Plan Document

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

Relationship with Providers

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

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

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

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

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

Your Relationship with Providers

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

- You are responsible for choosing your own provider.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.

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- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

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

Incentives to Providers

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

Examples of financial incentives for Network providers are:

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

The methods used to pay specific Network providers may vary. From time to time, the payment method may change. If you have questions about whether your Network provider's contract includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact the Claims Administrator

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at the telephone number on your ID card. They can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

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

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

Administrative Services

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

Amendments to the Plan

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 resolution and a written amendment (in the case of a change or amendment)**, 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.

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Clerical Error

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

Information and Records

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

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

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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.

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.

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Medicare Eligibility

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

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

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

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

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Subrogation and Reimbursement

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

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

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

You agree as follows:

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

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

Refund of Overpayments

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

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

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

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

Limitation of Action

You cannot bring any legal action against us or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in (Section 5: How to File a Claim). If you want to bring a legal action against us or the Claims Administrator you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted, or you lose any rights to bring such an action against us or the Claims Administrator.

You cannot bring any legal action against us or the Claims Administrator for any other reason unless you first complete all the steps in the complaint process described in (Section 6: Questions, Complaints, Appeals). After completing that process, if you want to bring a legal action against us or the Claims Administrator you must do so within three years of the date you are notified of our final decision on your complaint, or you lose any rights to bring such an action against us or the Claims Administrator.

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Section 10: Glossary of Defined Terms

This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

Covered Person - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Plan. References to "you" and "your" throughout this 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 Subscriber's legal spouse or an unmarried dependent child of the Subscriber or the Subscriber's spouse. The term child includes any of the following:

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

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

- A Dependent includes any unmarried dependent child **less than 19 years of age.**
- A Dependent includes an unmarried dependent child who is 19 years of age or older, but less than 23 years of age who is also a Full-time Student at an accredited school. (See definition of Full-time Student.) Verification of student status is made at the time a claim is filed.

We also cover the dependent children of a qualified Dependent child.

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

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

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

- Can withstand repeated use and is not consumable or disposable.
- Used to serve a medical purpose.
- Generally not useful to a person in the absence of Sickness or Injury.
- Appropriate for use in the home.

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

Eligible Expenses are based on 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.
- 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.

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

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Administrator's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

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

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

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

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

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

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

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

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

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

Full-time Student - a person **age 19 to 23** who is enrolled in and attending a recognized course of study or training at one of the following:

- An accredited high school.

- An accredited college or university. **For college students, minimum credit hours are ten credit hours per quarter or semester for undergraduates or six credit hours per quarter or semester for graduate students.**
- A licensed vocational school, technical school, beautician school automotive school or similar training school. **Students must be taking a minimum of a two-thirds normal class schedule.**

You are no longer a Full-time Student at the end of the month you graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

You continue to be a Full-time Student during periods of regular vacation established by the institution, **including non-attendance one quarter or semester per year**. If you do not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end as described above.

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

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

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

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

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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.

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

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

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

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to

be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Health Services and products included in the participation agreement, and a non-Network provider for other Health Services and products. The participation status of providers will change from time to time.

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

Non-Network Benefits - Benefits for Covered Health Services that are provided by a non-Network Physician 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. We and the Plan Administrator will agree upon the period of time that is the Open Enrollment Period.

Out-of-Pocket Maximum - the maximum amount of Annual Deductible and Copayments you pay every calendar year. Once you reach the Out-of-Pocket Maximum for Network or Non-Network Benefits, Benefits are payable at 100% of Eligible Expenses during the rest of that calendar year. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum, as specified in (Section 1: What's Covered--Benefits).

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

- Any charges for non-Covered Health Services;
- Copayments for Covered Health Services available by an optional Rider.
- The amount of any reduced Benefits if you don't notify the Claims Administrator as described in (Section 1: What's

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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.

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

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

Plan - Franklin County Board of Commissioners Health Benefit Plan.

Plan Administrator - Franklin County Board of Commissioners or its designee as that term is defined under ERISA.

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

Pregnancy - includes all of the following:

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

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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.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Certificate 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.

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

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

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.

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

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

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

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

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Attachment I

Summary Plan Description

Name of Plan: Franklin County Board of Commissioners Health Benefit Plan

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

Franklin County Board of Commissioners
373 S. High Street, 25th Floor
Columbus, OH 43215-6314
(614) 462-5750

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

Employer Identification Number (EIN): 31-6400067

IRS Plan Number: 501

Effective Date of Plan: January 1, 2006

Type of Plan: Group health care coverage plan.

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

Franklin County Board of Commissioners
373 S. High Street, 25th Floor
Columbus, OH 43215-6314
(614) 462-5750

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

United HealthCare Insurance Company
450 Columbus Blvd.
Hartford, CT 06115-0450

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

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. The Plan Sponsor also has selected a provider network established by United HealthCare Insurance Company. The named fiduciary of Plan is Franklin County Board of Commissioners, the Plan Sponsor.

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Person designated as agent for service of legal process:

Plan Administrator.

Source of contributions under the Plan:

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

Method of calculating the amount of contribution:

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

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

The Plan year shall be a twelve month period ending December 31st.

Determinations of Qualified Medical Child Support Orders.

The Plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

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

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

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Attachment II

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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