GENERAL BOARD OF PENSION AND HEALTH BENEFITS
OF THE UNITED METHODIST CHURCH

Caring For Those Who Serve

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www.gbophb.org

HealthFlex Benefits Booklet

UnitedHealthcare Services, Inc. (UHC)

- Preferred Provider Medical Benefits (PPO Plan)
- Exclusive Provider Medical Benefits (EPO Plan)
- Consumer-Driven Health Plan (CDHP)
- Medco Prescription Drug Plan
- Vision Service Plan (VSP)

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Welcome

The General Board of Pension and Health Benefits of The United Methodist Church, Incorporated in Illinois (General Board) has prepared this Benefit Booklet to help you understand your health benefits administered by UnitedHealthcare Services, Inc. (UHC or the Claims Administrator). Please read it carefully.

About the Plan

The General Conference of The United Methodist Church permitted the establishment of a welfare benefit program for clergy and lay employees effective January 1, 1961. The Hospitalization and Medical Expense Program, also known as HealthFlex (Plan), is maintained for the benefit of clergy and lay employees (and their Dependents) of The United Methodist Church.

The Plan is a "Church Plan" as defined in Section 414(e) of the Internal Revenue Code of 1986 (Code), as amended, and Section 3(33) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The Plan's status as a Church Plan has a significant legal meaning; you can read more about it in the section titled *Other Important Provisions*.

Serving The United Methodist Church

The General Conference established the General Board to supervise and administer the employee benefit plans of The United Methodist Church. The General Board, in accordance with the provisions of *The Book of Discipline*, performs its duties for the supervision and administration of the Plan, and fulfills its responsibilities in the spirit of the Church's mandate for inclusiveness and racial and social justice.

Our Role in Providing Health Care Coverage and Controlling Costs

It is our mission to deliver compassionate Christian care balanced with financial stewardship on behalf of all Participants. We strive to ensure clergy and lay employees across the denomination are able to elect comprehensive health care coverage through the Plan. There are a variety of ways the General Board is responding to the increasing costs of health care, including benchmarking the Plan to make sure it remains competitive, evaluating the Plan's quality and networks, and negotiating with third-party administrators to ensure the Plan obtains the best possible rates for the desired services. There are things you can do, too, to control your own health care costs as an informed consumer of health care services. You can learn more about the steps you can take to control your health care costs at the HealthFlex/WebMD website or by asking your Physician.

Explanation of Terms

You will find terms starting with capital letters throughout this Benefit Booklet. To help you understand your benefits, most of these terms are defined in the *Definitions* section of this Benefit Booklet.

Plan Sponsor

Your Plan Sponsor is the employer or Conference through which your coverage under the Plan is coordinated. Your Plan Sponsor has elected to participate in the Plan through an adoption agreement with the General Board. If you have questions about your benefits under the Plan, you may contact your Plan Sponsor in addition to the General Board.

Confidentiality and HIPAA

The privacy of the health records of Plan Participants and their Dependents is protected by specific security and privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under HIPAA, General Board employees and Plan representatives and agents (such as UHC, Medco and others) may not release Protected Health Information, known as PHI, to a Participant's Plan Sponsor, Spouse or any other entity (unless required by law) unless the Participant authorizes such release. HIPAA also applies when you want PHI to be shared among health plans and Providers for reasons other than payment or treatment. The General Board's Notice of Privacy Practices describes the Plan's privacy practices and your rights to access your records. The notice is available on the website, **www.gbophb.org**.

The General Board will require your written authorization before disclosing your PHI to anyone other than you or your personal representative (that is, your guardian or named representative in a power of attorney). You may be asked to fill out and return authorization forms and to provide verification of information. Please remember that these and other actions are taken to safeguard the privacy of you and your family. Also, keep in mind that from time to time employees and agents of the General Board, such as the Claims Administrator, may access PHI, subject to the rules of HIPAA and the privacy policies of the General Board, as part of their day-to-day function of administering the Plan.

Your Responsibility to Provide Accurate Information

The Plan Administrator and Claims Administrator rely on information provided by you when evaluating coverage and benefits under the Plan. All such information, therefore, must be accurate, truthful and complete. Any fraudulent statement, omission or concealment of facts, misrepresentation, or incorrect information may result in the denial of a claim, cancellation or rescission of coverage, or any other legal remedy available to the Plan.

Questions

If you have questions about the benefit plans administered by the General Board, please do not hesitate to contact us. The General Board welcomes you to HealthFlex and looks forward to serving you.

For more information, please visit our website at **www.gbophb.org**. Or you may call the General Board Health Team at **1-800-851-2201**.

The Schedule

The Schedule is a brief outline of your benefits payable under the Plan. For a full description of each benefit, refer to the appropriate section listed in the *Table of Contents*.

Plan Document Controls

If any discrepancy exists between this Benefit Booklet and the terms and conditions set forth in the official plan document of the Hospitalizations and Medical Expense Program (Plan Document) or the Summary Plan Description (SPD), the terms of the Plan Document and SPD shall govern.

Eligibility

If you are appointed to or work for a Plan Sponsor of HealthFlex, you may be eligible for coverage under the Plan. Your eligibility depends on the rules of the Plan and the choices of your Plan Sponsor. Contact your Plan Sponsor or the General Board if you have questions about your eligibility under the Plan. For more information about the HealthFlex eligibility rules, please refer to the *HealthFlex Summary Plan Description*, or contact your Plan Sponsor or the General Board.

Cafeteria Plan Rules

For information about the cafeteria plan portion of HealthFlex and the rules that govern the cafeteria plan, including the rules about your ability to make elections under HealthFlex, under §125 of the Code, please refer to the *HealthFlex Summary Plan Description* or contact your Plan Sponsor or the General Board.

Through the cafeteria plan, you may pay the portion of the Required Contribution (premium) that is your responsibility as Employee on a tax-advantaged basis, and your Plan Sponsor may also offer flexible spending accounts (FSAs) for medical expenses and dependent care. FSAs can help you pay for medical expenses not covered under the Plan (i.e., Co-payments, Deductibles, dependent day care and other exclusions, on a tax-advantaged basis). You should ask your Plan Sponsor about the availability of an FSA.

Important Notices

NOTICE OF FEDERAL REQUIREMENTS

Coverage for Reconstructive Surgery Following Mastectomy
When a Participant who has had a mastectomy at any time decides to have breast reconstruction, based on consultation between the attending Physician and the patient, the following benefits will be subject to the same Co-payment, Co-insurance and Deductibles that apply to other Plan benefits:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- treatment of physical complications in all stages of mastectomy, including lymph edema; and
- mastectomy bras and external prostheses limited to the lowest-cost alternative available that meets the patient's physical needs.

The coverage described above is consistent with the requirements of the Women's Health and Cancer Rights Act of 1998 (Cancer Rights Act). Though the Cancer Rights Act is not directly applicable to the Plan because it is a Church Plan, the benefits described above are available to Participants.

If you have any questions about your benefits under this Plan, please call the toll-free number on the back of your ID Card.

Statement of Rights Under the Newborns and Mothers' Health Protection Act
Group health plans 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, or require that a Provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending Provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

Notice of Patient Protections

The Plan generally allows the designation of a primary care Provider. You have the right to designate any primary care Provider who participates in the HealthFlex Plan's network, i.e., is a Participating Provider that is a primary care Provider, and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care Provider. For information on how to select a primary care Provider and for a list of the Participating Providers, you can access UnitedHealthcare's website at **www.myuhc.com**.

You do not need prior authorization from HealthFlex or from any other person (including a primary care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network who specializes in obstetrics or gynecology. The

Provider you choose, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or following procedures for making referrals. For a list of Participating Providers who specialize in obstetrics or gynecology, you can access UHC's website at **www.myuhc.com**.

Notice of Federal Requirements Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment with respect to military leaves of absence. These requirements may apply to medical coverage for you and your Dependents. They do not apply to any life, short-term or long-term disability, or accidental death and dismemberment coverage.

Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the *Termination of Coverage* section regarding leave of absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

- You may continue benefits, by paying the required contribution to your employer or Plan Sponsor, as applicable, until the earliest of the following:
  - for a period of time as determined by your employer or Plan Sponsor from the last day of employment with the employer or Plan Sponsor,
  - the day after you fail to apply or return to work, and
  - the date the Plan is terminated.
- The Plan may charge you and your Dependents up to 102% of the total required contribution.

Reinstatement of Benefits

If your coverage ends during the leave because you do not elect continuation coverage and you are re-employed by your current employer or Plan Sponsor, coverage for you and your Dependents may be reinstated if: a) you gave your employer or Plan Sponsor advance written or verbal notice of your military service leave, and b) the duration of all military leaves while you are employed with your current employer or Plan Sponsor does not exceed five years.

You and your Dependents will be subject to only the balance of a Pre-Existing Condition Waiting Period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply. Any 63-day break in coverage rule regarding credit for time accrued toward a Pre-existing Condition Waiting Period will be waived.

Time Frames for Requesting Re-employment
When a leave ends, you must report your intent to return to work as follows:

- For leaves of less than 31 days or for a fitness exam, by reporting to your employer or Plan Sponsor by the next regularly scheduled work day following eight hours of travel time;
- For leaves of 31 to 180 days, by submitting an application to your employer or Plan Sponsor within 14 days; and
- For leaves of more than 180 days, by submitting an application to your employer or Plan Sponsor within 90 days.

Consult your employer or Plan Sponsor for more details regarding your rights and your employer or Plan Sponsor's obligations for re-employment.

Claims

HOW TO FILE A MEDICAL CLAIM
In order to obtain your medical benefits under this Plan, it is necessary for a Claim to be filed with the Claims Administrator. To file a Claim, usually all you will have to do is show your ID Card to your Hospital or Physician (or other Provider). They will file your Claim for you. Remember, however, it is your responsibility to ensure that the necessary Claim information has been provided to the Claims Administrator.

Once the Claims Administrator receives your Claim, it will be processed and the benefit payment will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how much was paid; this is called an Explanation of Benefits (EOB). In some cases the Claims Administrator will send the payment directly to you or, if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claims Administrator's records.

In certain situations, you will have to file your own Claims. This is primarily true when you are receiving Services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

- Complete a Claim Form. These are available from your Plan Sponsor, the General Board, or from the Claims Administrator's office or website.
- Attach copies of all bills to be considered for benefits. These bills must include the Provider's name and address, the patient's name, the diagnosis, the date of service, and a description of the service and the Claim Charge.
- Mail the completed Claim Form with attachments to:

  UnitedHealthcare Insurance Company
  Attention Claims
  P.O. Box 740800
  Atlanta, Georgia 30374-0800

When you request payment of a Claim from the Claims Administrator, you must provide all of the following information:

- Participant's name and address.
- The patient's name, age and relationship to the Participant.

- The number stated on your ID Card.
- 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, and
  - Service provider's name, address and tax identification number.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other group health plan or insurance program. If you are enrolled for other coverage you must include the name of the other carrier(s).

In any case, Claims must be filed no later than 12 months after the date a service is received. Claims not filed within 12 months from the date a service is received may not be eligible for payment, or will be subject to reduced payment.

Should you have any questions about filing Claims, contact the General Board or call the Claims Administrator's office.

CLAIMS PROCEDURES

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. The Claims Administrator may suspend your Claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the Claim is denied, the Claims Administrator will notify you of the denial within 30 days after the information is received. If you do not provide the needed information within the 45-day period, your Claim will be denied.

A denial notice will 1) explain the reason for denial, 2) refer to the part of the Plan on which the denial is based, and 3) provide the Claim appeal procedures.

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 five 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. The Claims Administrator may request a one-time extension not longer than 15 days. The Claims Administrator may suspend your Claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you do

not provide the needed information within the 45-day period, your Claim will be denied. A denial notice will: 1) explain the reason for denial, 2) refer to the part of the Plan on which the denial is based, and 3) provide the Claim appeal procedures.

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 (if the Claim is denied) may be provided verbally, with a written or electronic confirmation to follow within three days.

If you filed an Urgent Care Claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within one business day (approximately) after the Urgent Care 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 72 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: a) explain the reason for denial, b) refer to the part of the Plan on which the denial is based, and b) provide the Claim appeal procedures.

CLAIM REVIEW PROCEDURES

Internal Review Process
If your Claim has been denied in whole or in part, you may have your Claim reviewed. The Claims Administrator will review its decision in accordance with the following procedure.

Within 180 days after you receive notice of a denial or partial denial, write to the Claims Administrator. The Claims Administrator will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

Urgent Care – Call Care Coordination

Pre-Service – To request review before receive care, submit written appeal to the P.O. Box address on the initial determination letter or:

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

Post-Service – To request review after you receive care, submit written appeal as directed on the EOB or:

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

You may also designate a representative (such as a family member or attorney) to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.

You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial.

If you have any questions about the Claims Procedures or the review procedure, write or call the Claims Administrator headquarters.

UnitedHealthcare Insurance Company
450 Columbus Boulevard
Hartford, CT 06115-0450

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

- For appeals of pre-service Claims, the first-level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied Claim. The second-level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

- For appeals of post-service Claims, the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied Claim. The second-level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first-level appeal decision.

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

For pre-service and post-service Claim appeals for benefits under the terms of this Benefit Booklet, the General Board has delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Plan. The Claims Administrator’s decisions are conclusive and binding.

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

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 Care 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 Care Claim appeals for benefits under the terms of this Benefit Booklet, the General Board has 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.

If you have filed a Claim for benefits and have asked the Claims Administrator to review your Claim, if it was initially denied, in whole or in part, and your Claim has been denied, in whole or in part, upon request for review, you may, only upon exhaustion of these administrative remedies, file suit in state or federal court.

In accordance with the Patient Protection and Affordable Care Act (PPACA), because the Plan is not a "grandfathered plan" you have additional rights to appeal claims. The Claims Administrator will follow the terms of the PPACA and the regulations issued by the U.S. Department of Health and Human Services implementing the PPACA regarding claims, appeals and external reviews.

If the Claims Administrator has denied your Claim for Benefits, in whole or in part, for a requested treatment or service, and/or rescinded your coverage, then you will receive a notice of adverse benefit determination. Subject to privacy laws and other restrictions, if any, the Claims Administrator will make available to you certain information including, for example, the date of service, healthcare provider, diagnosis, treatment and denial codes with their meanings, along with the reason for denial.

If, at any time, you need assistance with the internal claims and appeals or external review processes, you may contact the health insurance consumer assistance office or ombudsman established by the Department of Health and Human Services (HHS). You may check the HHS website or call the number on the back of your ID Card for contact information.

Claims Process and Additional Internal Appeal Rights under the PPACA
The Claims Administrator will notify you of urgent care claims benefit determinations not later than 24 hours after the receipt of your claim, unless you fail to provide sufficient information. The Claims Administrator will notify you of the missing information and you will have no less than 48 hours to provide the information. A benefit determination will be made within 72 hours after the missing information is received. You have the option of presenting evidence and testimony to the Claims Administrator in writing, by phone or in person at a designated location. Please reference the address and phone number information above. The Claims Administrator will provide you with any new or additional evidence or rationale and any other information and documents used in the adverse benefit determination so you have a reasonable opportunity to respond before a final decision is made. You have 180 days from the date you receive notice of adverse benefit determination to file an internal appeal, and the Claims Administrator's appeal decision will be sent to you within 60 days of receipt of your appeal request.

External Review Process
If a final determination to deny benefits is made, you may choose to participate in the Claims Administrator's voluntary external review program. This program only applies if the decision is based on either of the following:

- Clinical reasons, or
- Exclusion for Experimental, Investigational or Unproven Services.

The external review program is not available if the coverage determinations are based on explicit benefit exclusions or defined benefit limits. Contact the Claims Administrator at the telephone number shown on your ID Card for more information on the voluntary external review program.

You must file your request for external review within 4 months after receiving notice from the Claims Administrator of an adverse benefit determination or final internal adverse benefit determination. The Claims Administrator will complete a preliminary review of your request within 5 business days to determine whether you are eligible for external review. You may be required to exhaust the internal appeal process (described above) before being eligible for external review. You will be notified within 1 business day after the Claims Administrator completes the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the 4-month appeal period to complete the appeal request. If your Claim is not eligible for external review, the Claims Administrator will outline the reasons it is ineligible in the notice, and will provide contact information for the Department of Health and Human Services. Once an eligible request for external review is complete, the Claims Administrator will assign the matter to an independent review organization (IRO). The assigned IRO will be an independent, unbiased, randomly selected entity that receives no financial incentive based on the outcome of any review. There will be no charge to you for the IRO review. The acknowledgement of receipt of your request from the IRO will contain additional information about its review process, the types of additional information that you can submit for review, and the information that must be included in the decision of the IRO. You should note that the IRO is not bound by the adverse or final adverse benefit determination of the Claims Administrator. The IRO will retain appropriate clinical and legal consultants to conduct the review and issue a letter fully explaining its decision within 45 days after receipt of an eligible request for external review. The decision of the IRO is binding on the parties, but there may be additional state or federal remedies available. If the IRO reverses the adverse or final adverse benefit determination, the Claims Administrator will immediately provide coverage or payment for the Claim.

Expedited external review: You may seek expedited external review in certain circumstances where any delay in issuing a benefit determination would seriously jeopardize your life, health or ability to regain maximum function, or your claim involves emergency treatment and you have not been released from the treating facility. Upon receipt of the request for expedited external review, we must immediately notify you whether the request is complete and eligible for external review. If the claim is eligible for an expedited external review, we will assign the claim to an IRO and provide the IRO with all relevant information electronically, by phone, fax, or by other expeditious means. The IRO's process will be equivalent to a standard review, but must be completed as quickly as circumstances require and no later than 72 hours after the IRO receives the review request.

Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

Note: The preceding Claims procedures apply only to Claims for medical benefits under the Plan. The Claims procedures for Prescription Drug benefits are described in the *Prescription Drugs Benefits* section of this Benefit Booklet.

Eligibility Claims: If the Plan Administrator (General Board) has denied or limited your Claim for eligibility or rescinded your coverage, then you will receive a notice of adverse benefit determination. The General Board will make available to you certain information including the reason for denial. For information about the Claim review procedures and appeal process for eligibility Claims, please review the *HealthFlex Summary Plan Description*.

Important Information About Your Medical Plan

YOUR ID CARD

You will receive an identification card (ID Card). This card will include your identification number and will be very important to you in obtaining your benefits.

OBTAINING YOUR MEDICAL BENEFITS—PPO PARTICIPANTS AND CDHP PARTICIPANTS

The Plan has selected UnitedHealthcare Insurance Company as the administrator of its medical benefits for certain geographic areas. Medical benefits are administered separately from the other components of the Plan, such as Prescription Drug benefits, dental benefits and others.

Network Providers (i.e., in the network of Providers that is available to you through the Claims Administrator)have agreed to accept discounted payments for Covered Services with no additional billing to the Participant other than Co-payments, Co-insurance and Deductible amounts. You may obtain further information about the Network status of Professional Providers and information on Out-of-Pocket expenses by calling the toll-free telephone number on your ID Card.

On the other hand, you should be aware that when you obtain health care or medical services from a Non-Network Provider in non-Emergency situations, *you can expect to pay more than the Co-insurance amount described in The Schedule after the Plan has paid its required portion.* Non-Network Providers may bill Participants for any amount up to the total billed charge after the Plan has paid its portion of the bill.

You will receive the highest possible benefit for health care services when you obtain such services from Network Providers (you need to present your ID Card at the time of service).

OBTAINING YOUR MEDICAL BENEFITS—EPO PARTICIPANTS

The Exclusive Provider Option (EPO) is a program of health care benefits designed to provide you with economic incentives for using designated Providers (i.e., Network Providers) for health care services.

Benefits are payable for Covered Services that are any of the following:

- Provided by or under the direction of a Network Provider in the Provider's office or at a Network facility,
- Emergency Health Services, or
- Urgent Care Center services received outside the service area.

In the EPO, benefits are not payable for Covered Services that are provided by Non-Network Providers.

NETWORK GAP EXCEPTION

If specific Covered Services are not available from a Network Provider within a 30 mile radius from your home zip code, you may be eligible for benefits when Covered Services are received from Non-Network Providers. In this situation, you or your Physician should notify the Claims Administrator's Care Coordination[SM], and they will work with you to coordinate care through a Non-Network Provider.

For participants of the PPO, when you receive Covered Services through a Network Physician, the Claims Administrator will pay Network Benefits for those Covered Services, even if one or more of those Covered Services is received from a Non-Network Provider.

For participants of the EPO, the Plan provides benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician. The Plan provides benefits for Emergency Health Services even if you do not have a referral from a Network Provider. Whenever possible, you should contact the Claims Administrator before receiving Emergency Health Services, and then seek care from the Network Provider it designates. Benefits are paid for Emergency Health Services, even if the services are provided by a Non-Network Provider. Benefits for Emergency medical care services will be provided at the payment level specified in *The Schedule* of this Benefit Booklet.

NETWORK PROVIDERS

Network Providers are Providers who have signed an agreement with the Claims Administrator to accept the Eligible Expenses as payment in full. Such Network Providers have agreed not to bill you for Covered Services amounts in excess of the Eligible Expenses. Therefore you will be responsible only for the difference between the Claims Administrator's benefit payment and the Eligible Expenses for the particular Covered Service—that is, your Deductible, if applicable, and Co-payment amounts, unless you agreed to reimburse the provider for such services. However, before obtaining services you should always verify the Network status of a Provider. A Provider's status may change. You are responsible for verifying a Provider's Network status prior to receiving services, even when another Network Provider refers you. You can verify the Provider's status by calling the Claims Administrator or visiting the Claims Administrator's website. Do not assume that a Network Provider's agreement includes all Covered Services.

Some Network Providers contract to provide only certain Covered Services, but not all Covered 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.

NON-NETWORK PROVIDERS—APPLICABLE TO PPO PARTICIPANTS
When you receive Covered Services from Non-Network Providers (except for fees that are negotiated by a Non-Network Provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors), you are responsible for paying, directly to the Non-Network provider, the Co-payment, any difference between the amount the Provider bills you and the amount the Claims Administrator will pay for Eligible Expenses, and any amounts in excess of any Plan maximum.

NON-NETWORK PROVIDERS—APPLICABLE TO EPO PARTICIPANTS
If specific Covered Services are not available from a Network Provider, you may be eligible for benefits when Covered Services are received from Non-Network Providers. In this situation, you or your Physician will notify Care Coordination℠, and they will work with you to coordinate care through a Non-Network Provider.

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 cost effectiveness.
- Capitation—a group of Network Providers receives a monthly payment from the Claims Administrator for each Covered Person who selects a Network Provider within the group to perform or coordinate certain health services. The Network Providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

The methods used to pay specific Network Providers may vary. From time to time, the payment method may change. If you have questions about whether your Network Provider's contract includes any financial incentives, we encourage you to discuss those questions with your Provider. You may also contact the Claims Administrator at the telephone number on your ID Card. Customer services representatives 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.

LIFETIME MAXIMUM BENEFIT
There is no lifetime limit applied to eligible Benefits payable under the Plan.

CUMULATIVE BENEFIT MAXIMUMS
All benefits payable under this Plan are cumulative. Therefore, in calculating the benefit maximums payable for a particular Covered Service the Claims Administrator will include benefit payments under both this and any prior or subsequent health care program administered by the Claims Administrator issued to you as an Eligible Person or a Dependent of an Eligible Person under this Plan.

OUT-OF-POCKET MAXIMUMS—PPO PARTICIPANTS AND CDHP PARTICIPANTS
There are separate Out-of-Pocket Maximums applicable to Covered Services received from Participating Providers and Non-Participating Providers. Out-of-Pocket Maximums will cross-accumulate for Participating and Non-Participating Providers. In other words, charges incurred for Covered Services from either Network or Non-Network Providers will be used to satisfy both the Network Provider Deductible and Out-of-Pocket Maximum and the Non-Network Provider Deductible and Out-of-Pocket Maximum simultaneously, until the Network Provider Deductible and Out-of-Pocket Maximum have been satisfied. However, only Charges made by Non-Network Providers will be used to satisfy the remainder of the Non-Network Provider Deductible and Out-of-Pocket Maximum.

BENEFITS FOR MEDICARE-ELIGIBLE COVERED PERSONS
This section describes the benefits that will be provided for Medicare-Eligible Covered Persons, unless otherwise specified in this Benefit Booklet (see provisions titled *Medicare-Eligible Covered Persons* in the *Eligibility* section of this Benefit Booklet and *Medicare Eligibles* in the *Coordination of Benefits* section of this Benefit Booklet).

The benefits and provisions described throughout this Benefit Booklet apply to you; however, in determining the benefits to be paid for your Covered Services, consideration is given to the benefits available under Medicare.

The process used in determining benefits under the Plan is as follows:
- Determine what the payment for a Covered Service would be under the terms of this coverage; and
- Deduct from this resulting amount the amount paid or payable by Medicare. (If you are eligible for Medicare, the amount that is available from Medicare will be deducted whether or not you have enrolled and/or received payment from Medicare.) The difference, if any, is the amount that will be paid under the Plan.

When you have a Claim, you must send the Claims Administrator a copy of your Explanation of Medicare Benefits (EOMB) in order for your Claim to be processed. In the event you are eligible for Medicare but have not enrolled in Medicare, the amount that would have been available from Medicare, had you enrolled, will be used. If Medicare is the Primary Plan for your benefits for a reason listed in the section titled *Medicare Eligibles* in the *Coordination of Benefits* section of this Benefit Booklet and you would like automated filing of your EOMB so that you do not have to file a separate Claim through submitting a paper form with the Plan, contact UnitedHealthcare customer service at the phone number on your ID Card for further information.

Care Coordination Program

The Claims Administrator has established the Care Coordination Program℠ (Care Coordinator) to perform a review of many Covered Services prior to such services being rendered. The Care Coordinator is responsible for reviewing admissions to Inpatient facilities, determining Covered Services, and reviewing admission lengths of stay.

The Care Coordination Program staff is primarily made up of Registered Nurses and other personnel with clinical backgrounds. Physicians in the Claims Administrator's medical department also play an essential role in the Care Coordination Program. This program helps to ensure that you receive high-quality, cost-effective care when admitted to an Inpatient facility.

When you receive Covered Services from Network Providers, you are responsible for the Co-payment and amounts in excess of any Plan maximum, but 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.

Please read the provisions below carefully.

Note: You are required to contact the Care Coordinator program in certain situations, as outlined below. Call the toll-free telephone number on your UHC ID Card to contact the Care Coordinator.

Prior notification is required before you receive certain Covered Services. In general, Network Providers are responsible for notifying Care Coordination^{SM} before they provide these services to you. When your Network Provider notifies Care Coordination^{SM}, they will work together to implement the Care Coordination^{SM} process and to provide you with information about additional services that are available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy. If you receive certain Covered Health Services from a Network Provider, you must notify Care Coordination^{SM}. The Covered Health Services for which notification is required from you and not from a Network Physician are Emergency Dental Services and Reconstructive Procedures. When you notify Care Coordination^{SM}, you will be provided with the Care Coordination^{SM} services described above.

If you are a participant in the PPO, when you choose to receive certain Covered Services from a Non-Network Provider, you must notify Care Coordination^{SM}. Services for which you must provide prior notification appear in this section. The Covered Services for which notification is required from you are Emergency Dental Services, Reconstructive Procedures, and Durable Medical Equipment— for items costing more than $1,000. When you notify Care Coordination^{SM}, you will be provided with the Care Coordination^{SM} services described above.

INPATIENT PRE-ADMISSION AND ADMISSION REVIEWS

Whenever your Physician recommends a non-Emergency or non-maternity Inpatient Hospital admission, you should call the Care Coordinator at least 1 business day prior to the Hospital admission.

Pre-admission or Admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of the Plan as well as the Pre-existing Condition Waiting Period, if applicable.

If the proposed Hospital admission or health care services are not medically appropriate nor considered Eligible Expenses in the judgment of the Claims Administrator, the situation will be referred to the Claims Administrator's Physician for review. If the Claims Administrator's

Physician concurs that the proposed admission or health care services are not medically appropriate services for some days or the entire Hospitalization, the Claim will be denied. The Hospital and your Physician will be advised by telephone of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. The Care Coordinator will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission.

Emergency Admission Review
The Plan provides benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician. The Plan provides benefits for Emergency Health Services even if they are provided by a Non-Network Provider. Whenever possible, you should contact the Claims Administrator before receiving Emergency Health Services, and then seek care from the Network Provider it designates.

- If you are confined in a Non-Network Hospital after you receive Emergency Health Services, Care Coordination^{SM} must be notified within 2 business days or on the same day of admission if reasonably possible. Care Coordination^{SM} 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 Care Coordination^{SM} decides a transfer is medically appropriate, Non-Network benefits may be available if the continued stay is determined to be a Covered Service.
- For participants in the PPO: Non-Network benefits may be available if the continued stay is determined to be a Covered 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 Co-payment for Emergency Health Services. The Co-payment for an Inpatient Stay in a Network Hospital will apply instead.

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

Other Admissions: Whenever your Physician recommends an admission for the following health care Services, you must call the Care Coordinator.

- Skilled Nursing Facility Pre-admission Review;
- Coordinated Home Care Program Pre-admission;
- Private Duty Nursing Service Review;
- Hospice Care Program;
- Dental Accident only (Network and Non-Network);
- Reconstructive Procedures;
- Transplant Services;
- Durable Medical Equipment (for any single item of Durable Medical Equipment that costs more than$1,000 (either purchase price or cumulative rental of a single item); or
- Outpatient Surgery.

This call must be made at least 1 business day prior to the scheduling of the admission or receiving Services. When you call the Care Coordinator, a case manager may be assigned to you for the duration of your care.

Length of Stay/Service Review

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of the Plan as well as the Pre-existing Condition Waiting Period, if any.

Upon completion of the pre-admission or Emergency admission review, the Care Coordinator will send you a letter confirming that you or your representative called the Care Coordinator. A letter assigning a length of service or length of stay will be sent to your Physician and/or the Hospital.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care Service is medically appropriate as determined by the Care Coordinator. In the event that the extension is determined not to be medically appropriate, the length of stay/service will not be extended, and the case will be referred to the Claims Administrator's Physician for review.

Coverage Determination

The Care Coordinator will make the decision whether Inpatient care or other health care services or supplies are Covered Services. Should the Claims Administrator's Physician concur that the Inpatient care or other health care services or supplies are Covered Service, written notification of the decision will be provided to you, your Physician, and/or the Hospital or other Provider, and will specify the dates that are not in benefit. For further details regarding Covered Services and other exclusions from coverage under the Plan see the sections titled, *Services Not Covered, Covered Services, Definitions* and *General Limitations*.

The Care Coordinator does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between you and your Physician. The Care Coordinator's determination is limited to merely whether a proposed admission, continued Hospitalization or other health care service is a Covered Service under the Plan.

In the event that the Claims Administrator determines that all or any portion of an Inpatient Hospitalization or other health care service is not a Covered Service, the Claims Administrator and the Plan will not be responsible for any related Hospital or other health care service charge incurred.

Remember that your Plan does not cover the cost of Hospitalization or any health care services and supplies that are not Covered Services. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such Hospitalization, service or supply "Covered Services." Even if your Physician prescribes, orders, recommends, approves, or views Hospitalization or other health care services or supplies as medically appropriate, the Claims

Administrator will not pay for the Hospitalization, services or supplies if the Care Coordinator and the Claims Administrator's Physician decide they were not Covered Services.

DESIGNATED UNITED RESOURCE NETWORK FACILITIES AND OTHER PROVIDERS
If you have a medical condition that the Care Coordinator believes needs special services, it may direct you to a Designated United Resource Network Facility or other provider chosen by the program. If you require certain complex Covered Services for which expertise is limited, the Care Coordinator may direct you to a Non-Network facility or Provider. In both cases, your Claim for benefits will only be paid if your Covered Services for that condition are provided by or arranged by the Designated United Resource Network Facility or other Provider chosen by the Care Coordinator.

Care Coordinator Procedure

When you contact the Care Coordinator, you should be prepared to provide the following information:

- The name of the attending and/or admitting Physician,
- The name of the Hospital where the admission has been scheduled and/or the location where the service has been scheduled,
- The scheduled admission and/or service date, and
- A preliminary diagnosis or reason for the admission and/or service.

When you contact the Care Coordinator, the Care Coordinator:

- Will review the medical information provided and may follow up with the Provider,
- May refer you to a Network Provider for service, and
- May determine that the services to be rendered are not a Covered Service.

In some cases, if your condition requires care in a Hospital or other health care facility, the Care Coordinator may recommend an alternative treatment plan.

Alternative treatment benefits will be provided only so long as the Claims Administrator determines that the alternative treatment services are medically appropriate and cost effective. Care Coordination will continue to monitor your case for the duration of your condition. The total maximum payment for alternative treatment services shall not exceed the total benefits for which you would otherwise be entitled under the Plan. Provision of alternative treatment benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative treatment benefits shall not be construed as a waiver of any of the terms, conditions, limitations and exclusions of the Plan.

- You, your Dependent or an attending Physician can request Care Coordination services by calling the toll-free number shown on the back of your ID Card during normal business hours, Monday through Friday.
- You or your Dependent may be contacted by an assigned Care Coordinator who will explain in detail how the program works. Participation in the program is voluntary—no penalty or benefit reduction is imposed if you do not wish to participate in Care Coordination.
- Following an initial assessment, the Care Coordinator works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- The Care Coordinator arranges for alternate treatment services and supplies, as needed (for example, nursing Services or a Hospital bed and other Durable Medical Equipment for the home).
- The Care Coordinator also acts as a liaison between the Plan, the patient, his or her family and Physician as needed (for example by helping you to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the Care Coordinator continues to manage the case to ensure the treatment program remains appropriate to the patient’s needs.

While participation in Care Coordination is strictly voluntary, Care Coordination professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

Care Coordinator Appeal Procedure

If you or your Physician disagrees with the determination of the Care Coordinator prior to or while receiving Services, you may appeal that decision by contacting the Care Coordinator.

In some instances, the resolution of the appeal process will not be completed until your admission or Service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after Claim processing has taken place or upon receipt of the notification letter from the Care Coordinator, you may appeal that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

UnitedHealthcare Insurance Company – Appeals
P.O. Box 659773
San Antonio, Texas 78265-9773

You must exercise the right to this appeal as a precondition to taking any action against the Claims Administrator or the Plan Administrator, either at law or in equity.

Failure to Notify

The final decision regarding your course of treatment is solely your responsibility, and the Care Coordinator will not interfere with your relationship with any Provider. However, the Claims Administrator has established the Care Coordination Program for the specific purpose of assisting you in determining the course of treatment that will maximize your benefits described in this Benefit Booklet. Failure to notify the Care Coordinator when appropriate may prevent you from maximizing your benefit.

Medicare-Eligible Participants

The provisions of this Care Coordination Program do not apply to you if you are Medicare-eligible and have secondary coverage provided under the Plan.

Benefit Payment

If, while you are a Participant in the Plan, you or any one of your Dependents incurs Charges for Covered Services, the Claims Administrator will pay an amount shown in *The Schedule*.

Payment of any benefits will be subject to any applicable Co-payments, Deductibles and Maximum Benefits shown in *The Schedule*.

Full Payment Area (Applicable to Participants of the PPO and Participants of CDHP)

The Out-of-Pocket Maximum is the maximum amount you pay out-of-pocket every calendar year after the Annual Deductible is met. If you use both Network Benefits and Non-Network Benefits, two separate Out-of-Pocket Maximums apply. Depending on the geographic area and the service you receive, you may have access to Non-Network Providers who have agreed to discount their charges for Covered Services. If you receive Covered Services from these Providers, your Co-insurance for Non-Network Benefits will remain the same, however the total amount that you owe may be less than if you received services from other Non-Network Providers because the Eligible Expenses may be a lesser amount.

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

The following costs will never apply to the Out-of-Pocket Maximum:
- Any Charges for services that are not Covered Services,
- Charges that exceed Eligible Expenses, and
- Any amounts applied towards meeting your Annual Deductible.

Even when the Out-of-Pocket Maximum has been reached, the following will not be paid at 100%:
- Any Charges for services that are not Covered Services, and
- Charges that exceed Eligible Expenses.

NETWORK PROVIDER OUT-OF-POCKET MAXIMUM
When a Participant has incurred an amount of Out-of-Pocket Expenses equivalent to the Network Provider individual maximum as shown in *The Schedule*, benefits for that Participant for Covered Services from a Network Provider will become payable at the rate of 100% during the rest of that Calendar Year.

When either: a) you and your Dependents, or b) your Dependents have incurred a combined amount of Out-of-Pocket Expenses equivalent to the Network Provider family maximum as shown in *The Schedule*, benefits for you and all of your Dependents for expenses related to Covered Services from a Network Provider will become payable at the rate of 100% during the rest of that Calendar Year.

NON-NETWORK PROVIDER OUT-OF-POCKET MAXIMUM
When a Participant has incurred an amount of Out-of-Pocket Expenses equivalent to the Non-Network Provider Individual Maximum as shown in *The Schedule*, benefits for that Participant for expenses related to Covered Services from a Non-Network Provider will become payable at the rate of 100% during the rest of that Calendar Year.

When either: a) you and your Dependents, or b) your Dependents have incurred a combined amount of Out-of-Pocket Expenses equivalent to the Non-Network Provider family maximum as shown in *The Schedule*, benefits for you and all of your Dependents for expenses related to

Covered Services from a Non-Network Provider will become payable at the rate of 100% during the rest of that Calendar Year.

Any benefit Deductible applicable to specific benefits hereunder, if not yet satisfied, will continue to apply until satisfied.

Eligible Expenses

Eligible Expenses for Covered Services, incurred while the Plan is in effect, are determined by the Claims Administrator or by its designee. For a complete definition of Eligible Expenses that describes how payment is determined, see *Definitions*. The Plan has delegated to the Claims Administrator the discretion and authority to determine on its behalf whether a treatment or supply is a Covered Service and how the Eligible Expense will be determined. When you receive Covered Services from Network Providers, you are responsible for the Co-payment and amounts in excess of any Plan maximum, but 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.

When you receive Covered Services from Network Providers, you are responsible for the Co-payment and amounts in excess of any Plan maximum, but 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.

When you receive Covered Services from Non-Network Providers, except for fees that are negotiated by a Non-Network Provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors, you are responsible for paying, directly to the Non-Network Provider, the Co-payment, any difference between the amount the Provider bills you and the amount the Plan will pay for Eligible Expenses, and any amounts in excess of any Plan maximum.

The term Covered Services means the services listed below for which expenses incurred by or on behalf of an individual will be paid by the Claims Administrator, if the expenses are incurred after he or she becomes covered as a Participant under the Plan, are received prior to the date that any of the individual termination conditions listed in *Termination of Coverage* occurs, and meets all of the eligibility requirements specified in the Plan. Such services are considered Covered Services as determined by the Claims Administrator, to the extent that the services or supplies provided are recommended by a Physician and medically appropriate for the care and treatment of an Injury or a Sickness. Any applicable Co-payments, Deductibles or maximums are shown in *The Schedule*.

COVERED SERVICES
Covered Services under the Plan include the following:

- Charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Services will not include that portion of Charges for Bed and Board which is more than the Bed and Board Limits shown in *The Schedule*.
- Charges for licensed Emergency ambulance service to or from the nearest Hospital or Alternate Facility where the needed Emergency medical care and treatment can be provided.
- Transportation by professional ambulance (not including air ambulance) to and from a medical facility.
- Transportation by regularly scheduled airline, railroad or air ambulance to the nearest medical facility qualified to give the required treatment.
- Charges made by a Hospital, on its own behalf, or an Alternate Facility for medical care and treatment received as an Outpatient.

- Charges made by a Free-Standing Surgical Facility, on its own behalf, for medical care and treatment.
- Charges made by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility on its own behalf, for medical care and treatment; except that Covered Services will not include that portion of such Charges which is in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- Charges made for medically appropriate Prescription Drugs while an individual is confined in a Skilled Nursing Facility.
- Charges made by a Physician or a Psychologist for professional Services.
- Charges made by a Nurse for professional nursing service.
- Charges made for anesthetics and their administration, diagnostic X-ray and laboratory examinations, X-ray, radium and radioactive isotope treatment, chemotherapy, blood transfusions and blood not donated or replaced, oxygen and other gases and their administration, prosthetic appliances and dressings.
- Charges made for surgical and nonsurgical care of Temporomandibular Joint Dysfunction (TMJ) excluding appliances and orthodontic treatment.
- Charges made for an annual routine mammogram.
- Charges made for an annual Papanicolaou laboratory screening test (Pap test).
- Charges made for an annual Prostate-Specific Antigen test (PSA) and a digital rectal exam.
- Charges made for an annual colorectal cancer screening.
- Charges made for annual routine blood work.
- Charges made for visits for routine preventive care of a Dependent child under age 16 including physical examinations, routine diagnostics and immunizations.
- Charges made for visits for routine preventive care of adults age 16 and over including a physical examination, routine diagnostics and immunizations.
- Charges made for Renal Dialysis treatments made by a Hospital, dialysis facility or in your home under the supervision of a Hospital or dialysis facility.
- Charges made for counseling and medical services connected with surgical therapies (vasectomy and tubal ligation), excluding procedures to reverse sterilization.
- Charges made for laboratory services, radiation therapy, and other diagnostic and therapeutic radiological procedures.
- Charges for nutritional formulae when required for:
  - Treatment of inborn errors of metabolism or inherited metabolic disease (including disorders of amino acid and organic acid metabolism); or
  - Enteral feeding for which the nutritional formulae under state or federal law can be dispensed only through a Physician's prescription, and is the primary source of nutrition.
- Charges made for medical diagnostic services to determine the cause of erectile dysfunction, such as postoperative prostatectomy and diabetes. Psychogenic erectile dysfunction does not warrant coverage for penile implants.
- Charges made by a Hospital for maternity coverage will include coverage for mother and child for at least 48 hours of inpatient care following a vaginal delivery and at least 96 hours of inpatient care following a cesarean section. Less time may be provided if the attending Physician feels it is appropriate as deemed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics. Maternity coverage will also apply to Dependents who become pregnant.
- Charges for diagnosing, monitoring and controlling inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism.
- Charges made for the examination and testing of an assault victim to establish:

  - That sexual contact did or did not occur; and
  - The presence or absence of sexually transmitted disease or infection. Coverage will also include Charges made for the examination and treatment of injuries and trauma.
- Charges for inpatient care following a mastectomy. The length of stay is to be determined by the attending Physician after evaluation of the patient. Please note that benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. The Plan provides other services under the Women's Health and Cancer Rights Act, including breast prostheses and treatment of complications, in the same manner and at the same level as those for any Covered Service.
- Charges for family planning services including medical history, physical examination, related laboratory tests, medical supervision in accordance with generally accepted medical practice, other medical services, information and counseling on contraception implanted/injected contraceptives. Office visits, tests and counseling are subject to any Preventive Care Maximum shown in *The Schedule*.
- Charges for medically appropriate eye exams (required due to other medical conditions, such as diabetes).
- Dental Accident Care and Limited Dental Surgery Care
  - Charges made for dental services rendered by a dentist or Physician that are required as the result of an accidental injury.
  - Surgery benefits are limited to the following dental services:
    - Surgical removal of complete bony impacted teeth;
    - Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
    - Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth; and
  - Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses), treatment of fractures of facial bone, external incision and drainage of cellulites, incision of accessory sinuses, salivary glands or ducts and reduction of dislocation of, or excision of the temporomandibular joints.

The following benefits will be Covered Services for insulin-dependent and non-insulin-dependent diabetics as well as Covered Persons who have elevated blood sugar levels due to pregnancy or other medical conditions:

- Charges for Durable Medical Equipment, including glucagon emergency kits and podiatric appliances, related to diabetes.
- Charges for insulin, syringes, prefilled insulin cartridges for the blind, oral blood sugar control agents, glucose test strips, visual reading ketone strips, urine test strips, lancets, and alcohol swabs, when dispensed by Physician or home health care.
- Charges for training by a Physician, including a podiatrist with recent education in diabetes management, but limited to the following:
  - Medically appropriate visits when diabetes is diagnosed,
  - Visits following a diagnosis of a significant change in the symptoms or conditions warrant change in self-management,
  - Visits when re-education or refresher training is prescribed by the Physician, and
  - Medical nutrition therapy related to diabetes management.

Home Health Services

Charges made for Home Health Services when you:

- Require skilled care,
- Are unable to obtain the required care as an ambulatory Outpatient, and
- Do not require confinement in a Hospital or Other Health Facility.

Home Health Services are provided only if the Claims Administrator has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for non-skilled care (e.g., bathing, eating, toileting), Home Health Services will only be provided for you during times when there is a family member or caregiver present in the home to meet your non-skilled care needs.

Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health Services are covered. Home Health Services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Health Care Professional. Physical, occupational, and other Short-Term Rehabilitative Therapy Services provided in the home are not subject to the Home Health Services benefit limitations in *The Schedule*, but are subject to the benefit limitations described under Short-term Rehabilitative Therapy Maximum shown in *The Schedule*.

Hospice Care Services

The following Charges made due to Terminal Illness for the Hospice Care Services provided under a Hospice Care Program:

- By a Hospice Facility for Bed and Board and services and Supplies, except that, for any day of confinement in a private room, Covered Services will not include that portion of Charges which is more than the Hospice Bed and Board limit shown in *The Schedule*;
- By a Hospice Facility for Services provided on an Outpatient basis;
- By a Physician for professional services;
- By a Psychologist, social worker, family counselor or ordained minister for individual and family counseling, including bereavement counseling within 1 year after the person's death;
- For pain relief treatment, including drugs, medicines and medical supplies; and
- By Other Health Care Facility for:
  - Part-time or intermittent nursing care by or under the supervision of a Nurse,
  - Part-time or intermittent services of Other Health Care Professional,
  - Physical, occupational and speech therapy, and
  - Medical supplies, drugs and medicines lawfully dispensed only on the written prescription of a Physician, and laboratory services, but only to the extent that such Charges would have been payable under the Plan if the person had remained or been Confined in a Hospital or Hospice Facility.

The following Charges for Hospice Care Services are *not* included as Covered Services:

- For the Services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house,
- For any period when you or your Dependent is not under the care of a Physician,

- For services or supplies not listed in the Hospice Care Program,
- For any curative or life-prolonging procedures, or
- To the extent that any other benefits are payable for those expenses under the Plan, and for Services or supplies that are primarily to aid you or your Dependent in daily living.

Durable Medical Equipment

Charges made for the purchase or rental of Durable Medical Equipment that is ordered or prescribed and provided by a vendor approved by the Claims Administrator for use outside a Hospital or Other Health Care Facility. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of Durable Medical Equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a Participant's misuse are the Participant's responsibility.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person, customarily serve a medical purpose, generally are not useful in the absence of Injury or Sickness, are appropriate for use in the home, and are not disposable. Such equipment includes, but is not limited to, crutches, Hospital beds, wheel chairs and dialysis machines.

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.

Benefits are provided for the replacement of a type of Durable Medical Equipment once every 3 calendar years.

Care Coordination[SM] will decide if the equipment should be purchased or rented. To receive Network-level benefits, you must purchase or rent the Durable Medical Equipment from the vendor Care Coordination[SM] identifies.

Durable Medical Equipment items that are ***not covered***, include, but are not limited to, those that are listed below:

- ***Bed related items****:* bed trays, over the bed tables, bed wedges, custom bedroom equipment, non-power mattresses, pillows, posturepedic mattresses, low air mattresses (powered), alternating pressure mattresses.
- ***Bath related items****:* bath lifts, nonportable whirlpool, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand-held showers, paraffin baths, bath mats, spas.
- ***Chairs, lifts and standing devices:*** computerized or gyroscopic mobility systems, roll about chairs, geri chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized; manual hydraulic lifts are covered if the patient requires two-person transfer), vitrectomy chairs, auto tilt chairs and fixtures to real property (ceiling lifts, wheelchair ramps, automobile lifts customizations).
- ***Air quality items:*** room humidifiers, vaporizers, air purifiers and electrostatic machines.
- ***Blood/injection related items:*** blood pressure cuffs, centrifuges, nova pens and needle-less injectors.
- ***Pumps:*** back packs for portable pumps.

- ***Other equipment:*** heat lamps, heating pads, cryounits, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adapters, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, exercise equipment, diathermy machines.

External Prosthetic Appliances

- Charges made for the initial purchase and fitting of external prosthetic devices which are to be used as replacements or substitutes for missing body parts and are necessary for the alleviation or correction of Sickness, Injury or congenital defect.
- External prosthetic devices shall include: basic limb prosthetics; terminal devices such as hands or hooks; braces and splints; non-foot orthoses. Only the following non-foot orthoses are covered: a) rigid and semi-rigid custom fabricated orthoses; b) semi-rigid prefabricated and flexible orthoses; c) rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints; and d) FDA-approved cranial orthotic devices for the treatment of non-synostatic positional plagiocephaly. Custom foot orthotics are only covered as follows:
  - For Participants with impaired peripheral sensation and/or altered peripheral circulation (e.g., diabetic neuropathy and peripheral vascular disease),
  - When the foot orthotic is an integral part of a leg brace and it is necessary for the proper functioning of the brace,
  - When the foot orthotic is for use as a replacement or substitute for a missing part of the foot (e.g., amputation) and is necessary for the alleviation or correction of illness, injury or congenital defect, and
  - For Participants with neurologic or neuromuscular condition (e.g., cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.
- Wigs (also referred to as a cranial prostheses).
- First pair of Eyeglasses or contact lenses as a result of cataract surgery.
- Cranial orthoses.

The following are specifically ***excluded***:

- External power enhancements or power controls for prosthetic limbs and terminal devices;
- Orthotic shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers; and
- Orthoses primarily used for cosmetic rather than functional reasons.

Coverage for adjustments, replacement and repair of external prosthetic appliances is provided only when required due to reasonable wear and tear and/or anatomical change. All maintenance and repairs that result from the Participant's misuse are the Participant's responsibility.

Infertility Services

Charges made for Infertility Services, including services related to the treatment of infertility once a condition of infertility has been diagnosed. Also included are services for further diagnosis to determine the cause of infertility.

Infertility Services include, but are not limited to: infertility drugs, including injectable drugs, which are administered or provided by a Physician; Surgeries and other therapeutic procedures; laboratory tests, sperm washing or preparation, diagnostic evaluations, gamete intrafallopian

transfer (GIFT), in-vitro fertilization (IVF), uterine embryo lavage, embryo transfer, artificial insemination, zygote intrafallopian transfer (ZIFT), low tubal ovum transfer and the services of an embryologist. Infertility Services are payable as any other Sickness.

Benefits for in-vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures will be provided only when:

- Participant has been unable to attain or sustain a successful pregnancy through reasonable, less-costly medically appropriate infertility treatments; and
- Participant has not undergone four completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two more completed oocyte retrievals shall be covered.

In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer or zygote intrafallopian tube transfer procedures must be performed at medical facilities that conform to the American College of Obstetricians and Gynecology guidelines for in-vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in-vitro fertilization.

SPECIAL LIMITATIONS

This benefit includes diagnosis and treatment of both male and female infertility. However, the following are specifically *excluded* Infertility Services:

- Reversal of voluntary sterilization,
- Infertility Services when the infertility is caused by or related to voluntary sterilization,
- Donor Charges and services,
- Any experimental or investigational infertility procedures or therapies,
- Surrogate parenting,
- Fees or direct payment to a donor for maintenance and/or storage of frozen embryos,
- Health services and associated expenses for elective abortion,
- Fetal reduction Surgery, and
- Health services associated with the use of non-surgical or drug-induced pregnancy termination.

Short-Term Rehabilitative Therapy and Manipulative Therapy Services

Charges made for Short-Term Rehabilitative Therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following limitations apply to Short-Term Rehabilitative Therapy and Manipulative Therapy Services:

- Services that are considered custodial or educational in nature are not covered.
- Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy, and indicate the diagnosis and anticipated goals.
- Benefits will be provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished

under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy, and indicate the diagnosis and anticipated goals.

Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in the participant's condition within 2 months of the start of treatment.

Congenital speech therapy is limited to children from birth to age 3.

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

Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission.

Speech therapy is not covered when such treatment is intended to maintain speech communication or when it is not restorative in nature.

If multiple Outpatient services are provided on the same day they constitute one visit, but a separate Co-payment will apply to the services provided by each Provider.

Chiropractic Care
Charges made for Chiropractic Care or services as follows:

- Charges for care are limited to the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment that is rendered to restore motion, reduce pain and improve function.
- Charges for office examinations, including patient history, physical examination, spinal X-rays, laboratory tests, and neuromuscular treatment and manipulation.
- Charges for lab work.
- Charges are limited to medically appropriate care provided in an office setting.

Excluding any Charges for:

- Services of a Chiropractor that are not within the scope of his or her practice as defined by state law,
- Vitamin therapy, and
- Maintenance or Preventive Treatment.

Hearing Care Program
Your coverage includes benefits for hearing care when you receive such care from a Physician, Otologist and/or Audiologist.

The benefits of this section are subject to all of the terms and conditions described in this Benefit Booklet. Please refer to the *Services Not Covered* section of this Benefit Booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For hearing care benefits to be available, such care must be medically appropriate and you must receive such care on or after your Coverage Date.

In addition to the definitions of this Benefit Booklet, the following definitions are applicable to this *Benefit* section:

- Audiologist means a duly licensed audiologist.
- Hearing aid dealer means a Provider licensed to make and provide hearing aids to you.
- Otologist means a duly licensed otologist or otolaryngologist.

BENEFIT PERIOD

Your hearing care benefit period is a period of 1 year that begins on January 1 of each year. When you first enroll under this coverage, your first benefit period begins on your coverage date, and ends on the first December 31 following that date.

COVERED SERVICES

Benefits will be provided under this *Benefit* section for the following:

- Audiometric examination
- Hearing aid evaluation
- Conformity evaluation
- Hearing aids

Benefits will be limited to Covered Service(s) of each type listed above per benefit period.

SPECIAL LIMITATIONS

Benefits will not be provided for the following:

- Audiometric examinations by an Audiologist when not ordered by your Physician within 6 months of such examination;
- Medical or surgical treatment;
- Drugs or other medications;
- Replacement for lost or broken hearing aids, except if otherwise eligible under frequency limitations; or
- Hearing aids ordered while covered but delivered more than 60 days after termination.

BENEFIT PAYMENT FOR HEARING CARE

Benefits for hearing care Covered Services will be provided at the payment level specified in *The Schedule* of this Benefit Booklet.

For purposes of this *Hearing Care Program* section only, the definition of Maximum Allowance shall read as follows:

> Maximum Allowance means the amount as reasonably determined by the Claims Administrator, which is based on the fee which the Physician, Otologist or Audiologist who renders the particular service usually Charges patients or customers for the same service and the fee which is within the range of usual fees other Physicians, Otologists, Audiologists or Hearing Aid Dealers of similar training and experience in the same geographic area charge their patients or customers for the same service, under similar or comparable circumstances.

Human Organ Transplants
When ordered by a Physician, the following organ and tissue transplants will be Covered Services. For the highest level of benefits, transplant services must be received at a Designated United Resource Network Facility or Network Facility. Benefits are available for the transplants listed below when, in the reasonable judgment of the Claims Administrator, the transplant meets the definition of a Covered Service, and is not an Experimental or Investigational Service or an Unproven Service.

You must notify the Care Coordinator for all transplant services.

The Co-payment and annual Deductible will not apply to Network benefits when a transplant listed below is received at a Designated United Resource Network Facility. The services described under **Transportation and Lodging** below are Covered Services **only** in connection with a transplant received at a Designated United Resource Network Facility.

- Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Service. The search for bone marrow/stem cell from a donor who is not biologically related to the patient is a Covered Service only for a transplant received at a Designated United Resource Network Facility. If a separate charge is made for bone marrow/stem cell search, a Maximum Benefit of $25,000 is payable for all charges made in connection with the search.
- Heart transplants
- Heart/lung transplants
- Lung transplants
- Kidney transplants
- Kidney/pancreas transplants
- Liver transplants
- Liver/small bowel transplants
- Pancreas transplants
- Small bowel transplants

Benefits for cornea transplants that are provided by a Physician at a Network Hospital are paid as if the transplant were received at a Designated United Resource Network Facility. The Plan does not require that cornea transplants be performed at a Designated United Resource Network Facility in order for the Participant to receive the highest level of Network Benefits.

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage, i.e., they are not Covered Services, unless determined by the Care Coordinator to be a proven procedure for the involved diagnoses.

Under the Plan, there are specific guidelines regarding Benefits for transplant services. Contact the Care Coordinator at the telephone number on your ID Card for information about these guidelines.

Transportation and Lodging
The Care Coordinator will assist the patient and family with travel and lodging arrangements only when services are received from a Designated United Resource Network Facility. Expenses

for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
- Certain expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $200 for two people.
- Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Designated United Resource Network Facility.
- If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered, and lodging and meal expenses will be reimbursed up to the $200 per diem rate.

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

Notify the Care Coordinator

In order for transplant services to be paid as Network Benefits, to be Covered Services, the Participant or his/her physician must notify the Care Coordinator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).

In addition to the other exclusions of this Benefit Booklet, benefits will not be provided for the following:

- Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant surgery;
- Travel time and related expenses required by a Provider;
- Drugs that do not have approval of the U.S. Food and Drug Administration;
- Storage fees; and
- Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.

Breast Reconstruction and Breast Prostheses

Benefits for charges made for reconstructive Surgery following a mastectomy include:

- Surgical services for reconstruction of the breast on which Surgery was performed;
- Surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance;
- Postoperative breast prostheses; and
- Mastectomy bras and external prosthetics, limited to the lowest-cost alternative available that meets external prosthetic placement needs.

During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are Covered Services.

Reconstructive Surgery
Charges made for reconstructive Surgery or therapy to repair or correct a severe facial disfigurement or severe physical deformity (other than abnormalities of the jaw related to TMJ disorder) provided that:

- The Surgery or therapy restores or improves function;
- Reconstruction is required as a result of medically appropriate, non-cosmetic Surgery;
- The Surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part including, but not limited to microtia, amastia and Poland Syndrome.

Repeat or subsequent Surgeries for the same condition are Covered Services only when there is the probability of significant additional improvement, as determined the Claims Administrator.

Services Not Covered

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

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

The services, treatments, items or supplies listed in this section are not Covered Services, except as may be specifically provided for in *Covered Services*.

1. Health services and supplies that do not meet the definition of a Covered Service (see *Covered Services*; *Definitions*).
2. Services or supplies that are not specifically mentioned in this Benefit Booklet.
3. Services or supplies for any Sickness or Injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.
4. Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (e.g., Medicare) whether or not that payment or benefits are received, except however, this exclusion shall not be applicable to medical assistance benefits under Article V, VI or VII of the Illinois Public Aid Code (Ill. Rev. Stat. ch. 23 w 1–1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
5. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty. 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.
6. Services or supplies that do not meet accepted standards of medical and/or dental practice.
7. Investigational services and supplies and all related services and supplies, other than the cost of routine patient care associated with investigational cancer treatment, if those services or supplies would otherwise be covered under this Benefit Booklet if not provided in connection with an approved clinical trial program.

8. Custodial Care Service.
9. Long-term care service.
10. Inpatient Private-Duty Nursing Service.
12. Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness.
13. Cosmetic surgery or therapy and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases. Cosmetic Surgery or therapy is defined as Surgery or therapy performed to improve appearance or self-esteem.
14. Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
15. Charges for failure to keep a scheduled visit or Charges for completion of a Claim Form.
16. Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
17. Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this Benefit Booklet.
18. Blood derivatives that are not classified as drugs in the official formularies.
19. Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this Benefit Booklet.
20. Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.
21. Routine foot care, except for persons diagnosed with diabetes.
22. Immunizations, unless otherwise specified in this Benefit Booklet.
23. Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy.
24. Maintenance Care.
25. Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation.
26. Services and supplies to the extent benefits are duplicated because the Spouse, parent and/or child are covered separately under this Plan.
27. Premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, case-finding, research studies, screening, or similar procedures and studies, or tests which are investigational, unless otherwise specified in this Benefit Booklet.
28. Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.
29. Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this Benefit Booklet.
30. Elective abortions.
31. Services for the treatment of Mental Illness or mental and behavioral health conditions and substance abuse services and chemical dependency services that the Plan Administrator has elected to provide through a separate benefit plan.
32. Replacement of external prostheses due to loss, theft or destruction; or for any biomechanical external prosthetic devices.

33. Treatment of erectile dysfunction. However, penile implants are covered when an established medical condition is the cause of erectile dysfunction.
34. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or Hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court ordered, forensic or custodial evaluations.
35. Transsexual Surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such Surgery.
36. Therapy to improve general physical condition if not medically appropriate, including, but not limited to, routine, long-term chiropractic care, and rehabilitative services which are provided to reduce potential risk factors in patients in which significant therapeutic improvement is not expected.
37. Treatment by acupuncture and Acupressure, Aromatherapy, Hypnotism, Rolfing and Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health; services received by a naturopath or a naturalist; holistic or homeopathic care.
38. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets and dentures.
39. Court-ordered treatment or Hospitalization, unless such treatment is prescribed by a Physician and listed under the *Covered Services* section of this Benefit Booklet.
40. Non-medical ancillary services, including but not limited to, vocational rehabilitation, behavioral training, biofeedback neurofeedback, hypnosis, sleep therapy, employment counseling, back school, work hardening, driving safety; and services, training, educational therapy or other nonmedical ancillary Services for learning disabilities, developmental delays, autism or mental retardation.
41. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to, bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the *Home Health Services* or *Breast Reconstruction and Breast Prostheses* sections of *Covered Services*.
42. Private Hospital rooms and/or Private Duty Nursing unless determined by the Claims Administrator to be Covered Services.
43. Membership costs or fees associated with health clubs, weight loss programs whether or not they are under medical supervision, and smoking cessation programs. Weight loss programs for medical reasons are also excluded. Services received from a personal trainer. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
44. Amniocentesis, ultrasound, or any other procedures requested solely for gender determination of a fetus, unless medically appropriate to determine the existence of a gender-linked genetic disorder.
45. Genetic testing and therapy, including germ line and somatic, unless determined medically appropriate by the Claims Administrator for the purpose of making treatment decisions.
46. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Claims Administrator's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to Surgery.
47. Blood administration for the purpose of general improvement in physical condition.
48. Costs of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.

49. Cosmetics, dietary supplements, health and beauty aids and nutritional formulae. However, nutritional formulae are covered when required for: a) the treatment of inborn errors of metabolism or inherited metabolic disease (including disorders of amino acid and organic acid metabolism); or (b) enteral feeding for which the nutritional formulae under state or federal law can be dispensed only through a Physician's prescription and is the primary source of nutrition.

50. Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements and other articles which are not for the specific treatment of an Injury or Sickness.

51. Orthognathic treatment/Surgery, including but not limited to treatment/Surgery for mandibular or maxillary prognathism, microprognathism or malocclusion, Surgical augmentation for orthodontics, or maxillary constriction.

52. All noninjectable Prescription Drugs, nonprescription drugs, and investigational and experimental drugs.

53. For or in connection with an Injury or a Sickness that is a Pre-existing Condition, unless those expenses were incurred after a continuous one-year period during which a person satisfied the Pre-existing Condition Waiting Period.

54. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements.

55. Liposuction.

56. Respite Care Service

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

58. Charges for medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, if such condition meets the definition set out in the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute guidelines, in the view and discretion of the Claims Administrator and Plan Administrator, will be Covered Services, if the services are demonstrated, through peer-reviewed medical literature and scientifically based guidelines, to be safe and effective for treatment of the condition. Charges made for such treatments, i.e., bariatric Surgery procedures (sometimes called gastric bypass), will be Covered Services if and ***only*** if the terms of the HealthFlex Program for Bariatric Surgery: Requirements and Checklist (Requirements) are followed. The Requirements are specific and must be strictly adhered to for expenses related to bariatric Surgery to be considered Covered Services. Please contact the Claims Administrator or the Plan Administrator for a copy of the Requirements or for more information generally about the conditions of coverage for the treatment of clinically severe obesity. It is important to note that expenses related to bariatric Surgery will ***not*** be considered Covered Services if the Requirements are not followed.

59. Cosmetic Procedures. See the definition in *Definitions*. Examples include:

- Pharmacological regimens, nutritional procedures or treatments;
- Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
- Skin abrasion procedures performed as a treatment for acne; and

- 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 *Covered Services*.

60. 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.

Note: This exclusion does not apply to mammography testing.

61. Health services for organ and tissue transplants, except those described in Covered Benefits.

62. Health services connected with the removal of an organ or tissue from the Participant 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).

63. Health services for transplants involving mechanical or animal organs.

64. Any multiple organ transplant not listed as a Covered Service under the heading Human Organ Transplants, unless determined by Care Coordination[SM] to be a proven procedure for the involved diagnoses.

65. Health services provided in a foreign country, unless required as Emergency Health Services.

66. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Services rendered at United Resource Networks participating programs or Designated Facilities may be reimbursed at our discretion.

67. 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.

68. Growth hormone therapy.

69. Rest cures.

70. Psychosurgery.

71. Treatment of benign gynecomastia (abnormal breast enlargement in males).

72. Medical and surgical treatment of hyperhidrosis (excessive sweating).

73. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

74. Appliances for snoring.

75. Any Charges for missed appointments, room or facility reservations, completion of Claim forms or record processing.

76. 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.

77. Any Charge for services, supplies or equipment advertised by the Provider as free.

78. Any Charges by a Provider sanctioned under a federal program for reason of fraud, abuse or medical competency.

79. Any Charges prohibited by federal anti-kickback or self-referral statutes.

80. Chelation therapy, except to treat heavy metal poisoning.

81. Any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services.

82. Megavitamin and nutrition based therapy.

83. Except as described in *Covered Services,* nutritional counseling for either individuals or groups, including weight loss programs, health clubs and spa programs.

Creditable Coverage and Waiting Periods

PRE-EXISTING CONDITION WAITING PERIOD

Generally, your benefits are subject to a Pre-existing Condition Waiting Period of 365 days. Effective January 1, 2011, pre-existing condition exclusions no longer apply to individuals younger than age 19. The Pre-existing Condition Waiting Period will begin on the effective date of coverage for you and your eligible Dependents (if Family Coverage is effective) and will continue for the number of days specified. This Pre-existing Condition Waiting Period will also apply to each Dependent (other than a newborn child, an adopted child, or a child placed for adoption before age 19) for whom coverage is applied for after your effective date of coverage. The Pre-existing Condition Waiting Period for such a Dependent will begin on the Dependent's effective date of coverage.

This Pre-existing Condition Waiting Period does not apply to those persons who were Eligible Persons and applied for coverage at the time that the Plan became effective.

However, benefits for New Participant Groups will be limited to a maximum of $750 for Covered Services rendered in connection with a Pre-existing Condition during the first 365 days of coverage.

The Pre-existing Condition Waiting Period does not apply to the *Hearing Care Program* section of this Benefit Booklet.

A Pre-existing Condition is an Injury or a Sickness for which a person receives or is recommended treatment, incurs expenses or receives a diagnosis from a Physician during the 90 days before the earlier of the date a person begins an eligibility waiting period or becomes covered under the Plan for these benefits.

EXCEPTIONS TO PRE-EXISTING CONDITION WAITING PERIOD

Pregnancy, and genetic information with no related treatment, will not be considered Pre-existing Conditions.

A newborn child, an adopted child, or a child placed for adoption before age 19 will not be subject to any Pre-existing Condition Waiting Period if such child was covered within 31 days of birth, adoption or placement for adoption. Also, a Participant who neither seeks nor receives treatment for 6 months will not be subject to any Pre-existing Condition Waiting Period. Such waiver will not apply if 63 days elapse between coverage during a prior period of Creditable Coverage and coverage under this Plan.

CREDIT FOR COVERAGE UNDER PRIOR PLAN

If a person was previously covered under a plan which qualifies as Creditable Coverage, the following will apply, provided he or she notifies the General Board of such prior coverage, and fewer than 63 days elapse between coverage under the prior plan and coverage under this Plan, exclusive of any waiting period.

The Claims Administrator will reduce any Pre-existing Condition Waiting Period under the Plan by the number of days of prior Creditable Coverage a person had under a creditable group health plan or policy.

CERTIFICATION OF PRIOR CREDITABLE COVERAGE
The Participant must provide proof of prior Creditable Coverage in order to reduce a Pre-existing Condition Waiting Period. If this applies to you, submit proof of prior Creditable Coverage with your enrollment material. Certification, or other proofs of coverage which need to be submitted outside the standard enrollment process for any reason, may be sent directly to:

UnitedHealthcare Insurance Company
450 Columbus Boulevard
Hartford, CT 06115-0450

Contact the General Board or a UHC Customer Service Representative if assistance is needed to obtain proof of prior Creditable Coverage from your prior plan*****. Once your prior coverage records are reviewed and credit is calculated, you will receive a notice of any remaining Pre-existing Condition Waiting Period.

* You are entitled by federal law to be furnished with a copy of your Certificate of Creditable Coverage by your prior plan or policy.

CREDITABLE COVERAGE
Creditable Coverage will include coverage under: a self-insured Employer group health plan; individual or group health insurance indemnity or HMO plans; state or federal continuation coverage (e.g., COBRA coverage); individual or group health conversion plans; Part A or Part B of Medicare; Medicaid, except coverage solely for pediatric vaccines; the Indian Health Service; the Peace Corps Act; a state health benefits risk pool; a public health plan; health coverage for current and former members of the armed forces and their Dependents; a State Children's Health Insurance Program (S-CHIP); health coverage provided under a plan established by a foreign country; and health insurance for federal employees and their Dependents. Please contact a customer service representative at your prior plan, the Claims Administrator or the General Board if you have questions about prior Creditable Coverage.

Prescription Drug Benefits

Important note: The Prescription Drug benefits provided to Participants under the Plan are administered by Medco. If you have questions about your Prescription Drug benefits you may call Medco at **1-800-841-2806**, or visit **www.medco.com**.

Medco is the Claims Administrator for all Prescription Drug benefit Claims under the Plan. Do *not* send Claims for Prescription Drug benefits to UnitedHealthcare Insurance Company (the Claims Administrator for medical benefits). Please contact your Plan Sponsor or the General Board if you have any questions about to whom you should submit a Claim for your Prescription Drug or medical benefits. Please review this section carefully for information about Prescription Drug benefits under the Plan.

OBTAINING YOUR PRESCRIPTION DRUGS

The Plan has selected Medco as the administrator of its Prescription Drug benefits. Prescription Drug benefits are administered separately from the other components of the Plan, such as medical benefits. There are two ways to fill your prescriptions. You can use: 1) one of the 55,000 Participating Retail Pharmacies nationwide, or 2) the Medco Pharmacy (i.e., by mail, for long-term needs). You will receive the highest possible benefit for Prescription Drugs when you purchase medications at a Participating Retail Pharmacy (you must present your ID Card) or through the Medco Pharmacy. **Please Note**: *Participants will be allowed to obtain three fills of maintenance medication at the retail pharmacy. For all subsequent fills at the retail pharmacy, participants will be responsible for paying 100% of the discounted cost.* To maximize Plan benefits, refills for most maintenance medications will require fulfillment through the Medco by Mail Pharmacy Program.

Additional information about your Prescription Drug benefits, including the location of Participating Retail Pharmacies in your area, is available through the Medco website at **www.medco.com** (or through the HealthFlex/WebMD website at **www.gbophb.org**), or by telephone at **1-800-841-2806**.

You must present your ID Card when receiving Prescription Drugs and services from a Participating Retail Pharmacy. The Participating Pharmacy will verify your eligibility. You will be required to pay any applicable Deductibles or Co-payments at the time the prescription is obtained. The Pharmacist should notify you if a Generic Drug is available; however, it is in your best interest to also ask the Pharmacist about Generic Drug equivalents that may be available. To obtain maximum benefits for Prescription Drugs, you should usually choose Tier 1 Generic Drugs, when available.

PRESCRIPTION DRUG FORMULARY

Medco utilizes a Formulary management program designed to control costs for you and the Plan. The Formulary includes all U.S. Food and Drug Administration (FDA)-approved Prescription Drugs that have been placed in tiers based on their clinical effectiveness, safety and cost. Generally, Tier 1 includes primarily Generic Drugs; Tier 2 includes Formulary Brand Name Drugs; and Tier 3 includes Non-Formulary Brand Name Drugs and non-sedating antihistamines. You should share the Formulary listing with your Physician or practitioner, and encourage the Physician or practitioner to prescribe one of the Formulary products in order to potentially

decrease your Out-of-Pocket Expenses. While all currently FDA-approved Prescription Drugs are included on the Formulary list, the Plan may elect to exclude some drugs.

Please review the provisions of your Plan for specific drug exclusions. See *Drugs Covered* and *Drugs Not Covered* in this section for further information.

It is always up to you and your Physician to decide which prescriptions are best for you. You are never required to use Generic Drugs or Brand Name Drugs that are on the Medco Formulary list. If you prefer, you can use Non-formulary Brand Name Drugs and simply pay a higher Co-payment. It is also important to note that the Formulary list is routinely updated. To find the most up-to-date list of Covered Prescription Drugs or Preferred Formulary Drugs to share with your Physician, visit Medco's website at **www.medco.com**, or call Medco's member services department at **1-800-841-2806**. It is important to note that not all drugs listed on the Formulary are covered due to Plan exclusions and limitations. Please review the provisions of your Plan for specific exclusions. See the sections called *Drugs Covered, Drugs Not Covered,* and *General Limitations* for more information.

GENERIC MEDICATIONS AND GENERIC FIRST REQUIREMENT

Generic medications may have unfamiliar names, but they are safe and effective. Generic medications and their Brand Name counterparts have the same active ingredients and are manufactured according to the same strict federal regulations. Generic Drugs may differ in color, size or shape, but the FDA requires that the active ingredients have the same strength, purity and quality as their Brand Name counterparts. For this reason, the Plan will cover only the cost of the Generic Drug equivalent if you purchase a Brand Name Drug when there is an equivalent Generic Drug available. If you and your Physician choose a Brand Name Drug when there is an equivalent Generic Drug available, you will be charged one amount equal to the applicable Generic Drug Co-payment (e.g., $7.00) plus the cost difference between the Brand Name Drug and the Generic Drug.

If you have questions or concerns about generic medication, speak to your Physician or your Pharmacist, and he or she will be able to help you. You may also call Medco's member service number at **1-800-847-2806** to speak with a registered Pharmacist.

DRUGS COVERED

This section is intended to provide a general description of covered Prescription Drugs and supplies under the Plan at Participating Retail Pharmacies or the Medco Pharmacy (i.e., by mail). Generally, when you incur a Charge from a Pharmacy for Medically Necessary Prescription Drugs ordered by a Physician or a licensed dentist for prevention of infection or pain associated with an intensive procedure, the Plan will pay that portion of the Charge remaining after you have paid any applicable Co-payment. All FDA-approved drugs requiring a prescription to dispense are covered, unless specifically excluded under this Plan. Covered drugs and medical supplies include:

- Federal legend drugs, i.e., all drugs approved by the FDA and that require a prescription, except those listed under *Drugs Not Covered* in this section.
- State-restricted drugs.
- Insulin.
- Needles and syringes.
- Over-the-counter diabetic supplies (except for monitors and Glucowatch products).

- Oral, transdermal, intravaginal, and injectable contraceptives (except emergency contraceptives).
- Diaphragms and cervical caps.
- Inhaler assisting devices.
- Non-sedating antihistamine Brand Name Drugs will be paid as Tier 3, regardless of the drug's Formulary status. This is a result of the drugs Claritin and Zyrtec being available over-the-counter. The non-sedating antihistamine Generic Drug Fexofenadine will be covered as other Generic Drugs under the Plan.
- Prescription smoking cessation products (one-time 180-day supply for Chantix; one-time 90-day for other products).

MEDCO SPECIALTY PHARMACY

Specialty Pharmacy is the term used to describe certain Prescription Drugs and a set of services designed to meet the particular needs of people who take medications to treat certain conditions such as anemia/neutropenia, cancer, cystic fibrosis, deep vein thrombosis, Gaucher's disease, growth hormone deficiency, hepatitis C, immune deficiency, erectile dysfunction, infertility, multiple sclerosis, osteoarthritis, rheumatoid arthritis and respiratory syncytial virus. Many of these Prescription Drugs require injection and have special shipping and handling needs. The Medco Specialty Pharmacy service is designed to help individuals meet the particular needs and challenges of using certain Prescription Drugs, many of which require injection or special handling.

Medco's Specialty Pharmacy service includes:

- Support from Medco nurses and Pharmacists who are trained in specialty Prescription Drugs, their side effects, and the conditions they treat;
- Expedited delivery to the individual's home or Physician's office of all specialty Prescription Drugs;
- Some supplemental supplies, such as needles and syringes, required to administer the Prescription Drugs will be included at no additional charge; and
- Scheduling of refills and coordination of services with home care Providers, Case Managers, and Physicians or Other Healthcare Professionals.

If you are currently taking a Specialty Pharmacy Prescription Drug covered by the Plan and receive it through Medco Pharmacy (i.e., by mail), you are already pre-enrolled in the Specialty Pharmacy Program. If you currently receive Specialty Pharmacy Prescription Drugs from a Participating Retail Pharmacy and would like to find out if you are eligible to enroll in the Medco Specialty Pharmacy Program, call Medco toll-free at **1-800-803-2523**, Monday through Friday, 8:00 a.m. to 8:00 p.m., Eastern time.

If you are issued one of the Prescription Drugs listed under "Drugs Covered" above through the Medco Pharmacy for less than a 90-day supply, the Co-payment will be prorated accordingly (e.g., if a 30-day supply is dispensed, Medco will charge you only one-third of the standard Medco Pharmacy co-payment).

DRUGS REQUIRING PRIOR AUTHORIZATION

Some medications are covered only for specific medical conditions or for a specific quantity and duration regardless of what your doctor prescribes. A Medco Pharmacist, in cooperation with your Physician, determines coverage based on clinical guidelines and the manufacturer's

specifications to review the appropriateness of the medication, dosage and duration prescribed for certain conditions. Examples of medications that may require review are:

- Drugs to treat impotency for males only (except Yohimbine) and drugs for treatment of impotence related to diabetes, peripheral vascular disease or side effects of the medications to treat it, post-prostatectomy/orchiectomy, post-radiation therapy related to treatment of prostate cancer and syndromes affecting sexual functioning. Limited to six tablets per month.
- Myeloid stimulants.
- Neumega.
- Erythroid stimulants.
- Interferons (i.e., Alpha, Beta, Gamma, Pegasys).
- Multiple Sclerosis therapy (i.e., Avonex, Copaxone, Betaseron).
- Retin-A (tretinoin) (co-brands—cream only).
- Reganex gel.
- Penlac solution.
- Panrentin gel.
- Targretin gel.
- Protopic ointment.
- Elidel.
- Lupron 1 mg.
- Alzheimer's therapy (i.e., Cognex, Aricept, Exelon, Reminyl).
- Botox/Myobloc.
- Gleevec (Temodar, Avastin, Dacogen/Vidaza, Erbitux, Nexavar, Sprycel, Sutent, Vectibox)
- Hespera
- Zelnorm for females only.
- Xolair.
- Migraine Agents (i.e., Imitrex, Zomig, Maxalt).
- COX-2 medications.
- Human growth hormones.

If you submit a prescription for a drug at a Retail Pharmacy that requires review or prior authorization, your Pharmacist will tell you that approval is needed before the prescription can be filled. The Pharmacist will give you or your Physician a toll-free number to call. If you use the Medco Pharmacy, Medco will contact your Physician directly. When a coverage limit is triggered, more information is needed to determine whether your use of the Prescription Drug meets the Plan's coverage conditions. Medco will notify you and your Physician of the decision in writing. If coverage is approved, the letter will indicate the amount of time for which coverage is valid. If coverage is denied, an explanation will be provided, along with instructions on how to submit an appeal.

If you have any questions regarding coverage of a specific drug, please check the Medco website or call the member services department at **1-800-847-2806**.

DRUGS NOT COVERED

The Plan will not provide benefits for any of the items listed in this section, regardless of medical necessity or a prescription from a health care Provider The following list of Drugs not covered by the Plan is reviewed periodically and may change from time to time:

- Drugs not on the federal legend.

- Medication for which the cost is recoverable under any Workers' Compensation or occupational disease law, or from any state or governmental agency.
- Medication for which there is no legal obligation to pay, or medication furnished by a drug or medical service for which no charge is made to the individual.
- Medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent Hospital, nursing home, or similar institution that operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Any prescription refilled in excess of the number of refills specified by the Physician or practitioner, or any refill dispensed after one year from the Physician's or practitioner's original order.
- Drugs whose sole purpose is to promote or stimulate hair growth (e.g., Rogaine or Propecia) or for cosmetic purposes only (e.g., Renova or Vaniqa).
- Drugs labeled *Caution: Limited by federal law to investigational use*, or other experimental or investigational drugs, even though a charge is made to the individual.
- Drugs or medications, available over-the-counter, that do not require a prescription by federal or state law, and any drug or medication that is equivalent (in strength, regardless of form) to an over-the-counter drug or medication other than insulin. However, if a drug within this category is prescribed and is recommended by the United States Preventive Services Task Force (USPSTF) with an 'A' or 'B' grade, it will be covered.
- FDA-approved Prescription Drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, The American Medical Association Drug Evaluations or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal.
- Prescription and nonprescription supplies (such as ostomy supplies), devices and appliances other than syringes used in conjunction with injectable medications and glucose test strips, and gauze alcohol swabs.
- Norplant and other implantable contraceptive devices and products.
- Prescription vitamins (other than prenatal vitamins, injectable vitamin B-12 and injectable vitamin D) and dietary supplements. However, if a drug within this category is prescribed and is recommended by the United States Preventive Services Task Force (USPSTF) with an 'A' or 'B' grade, it will be covered.
- Prescription Drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth, as well as drugs used to control perspiration and fade cream products.
- Prescription smoking cessation products (in excess of a one-time 180-day supply for Chantix; one-time 90-day for other products).
- Immunization agents, immune globulins, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions, and medications used for travel prophylaxis.
- Medications used to enhance athletic performance.
- Medications which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing

pharmaceuticals. These medications are generally covered under the medical benefits portion of the Plan through UnitedHealthcare Insurance Company.
- Prescriptions obtained from a mail-order pharmacy that is not a part of the Medco Pharmacy.
- Topical dental fluorides.
- Therapeutic devices or appliances.
- Mifeprex.
- Drugs not approved by the FDA, such as those to treat impotency for females only.
- Yohimbine.
- Accutane.
- Appetite suppressants and weight-loss agents.
- Seasonale at a Retail Pharmacy is covered with a Co-payment equal to three times the standard Retail Pharmacy Co-payment.

Other limitations are described in the *General Limitations* section.

SHOULD I USE MEDCO PHARMACY OR A RETAIL PHARMACY?
When you need a Prescription Drug for a limited time, use a Participating Retail Pharmacy to maximize your benefits. If you need a Prescription Drug for an extended time (sometimes called a "maintenance drug"), you can maximize your benefits by using the Medco Pharmacy, which is a mail-order service for new and refill prescriptions. You can order prescriptions online **www.medco.com** or through the HealthFlex/WebMD website (**www.gbophb.org**) or by mail. Contact Medco at **1-800-847-2806** if you need assistance.

USING A RETAIL PHARMACY
Under the Plan, you are allowed a total of three fills of a maintenance medication at a Retail Pharmacy (one initial fill plus two refills). *Additional fills will not be covered by the Plan; you will pay for such fills at the full price.* Each fill can be for no more than a 30-day supply. Note that you are allowed a total of three fills at a retail pharmacy, even if each is for less than 30 days.

The amount you pay for Prescription Drugs depends on whether you use a Medco Participating Retail Pharmacy or a Non-Participating Pharmacy. At a Participating Retail Pharmacy, there are no Claim Forms to file; you simply pay your portion (i.e., your Co-payment, at the Participating Retail Pharmacy). Please refer to *The Schedule of Prescription Drug Benefits* at the end of this Booklet for details about Co-payments.

At a Non-Participating Retail Pharmacy, you must pay in full for your prescription and submit a Claim for reimbursement to Medco. If the Non-Participating Retail Pharmacy charges you more than the Allowable Amount (based on pricing at a Participating Retail Pharmacy), you will be reimbursed an amount equal to the Allowable Amount minus the Co-payment. You should mail your Claims for reimbursement to the address provided on the form.

Any reimbursement will be sent directly to you and made according to the Plan's Prescription Drug benefit provisions, as outlined on *The Schedule of Prescription Drug Benefits*. If any request for reimbursement is denied or reduced other than for Co-payments, please refer to the appeal provisions in the *Prescription Drug Appeals* section of this Benefit Booklet.

USING THE MEDCO PHARMACY (MAIL ORDER)
The Medco Pharmacy, also sometimes called "mail-order," should be used for maintenance (long-term) medications. You can receive up to a 90-day supply of medication for one Co-payment. Prescriptions must be filled as prescribed by your Physician—refills cannot be combined to equal a 90-day supply. Please refer to *The Schedule of Prescription Drug Benefits* for details about Medco Pharmacy Co-payments. If you submit a prescription for less than a standard 90-day supply of a Prescription Drug to the Medco Pharmacy and Medco is able, in its reasonable judgment, to dispense such supply, you will be charged a Co-payment for a full 90-day supply of the Prescription Drug.

Retail Refill Allowance (RRA) Program: The Plan has a Retail Refill Allowance Program policy. This Program requires that you use the Medco Pharmacy if you are prescribed a maintenance medication (long-term Prescription Drug), rather than refilling multiple prescriptions for the same Prescription Drug at a Retail Pharmacy. *If you or a covered Dependent receives a prescription for a maintenance medication and you do not use the Medco Pharmacy, your Prescription Drugs may not be covered.* Participants will be allowed to obtain three fills (the initial fill plus two refills) of maintenance Prescription Drugs at a Participating Retail Pharmacy. For all subsequent fills, Participants must use the Medco Pharmacy for the maintenance Prescription Drug to be covered. Otherwise, the Participant will be responsible for paying 100% of the discounted cost of the Prescription Drug.

In certain circumstances, you may not be required to use the Medco Pharmacy. For example, there are several categories of medications that are uniquely appropriate for multiple refills at your local Participating Retail Pharmacy (and are therefore exempt from the mandatory Medco Pharmacy provision that is outlined above).

If you have a prescription for any of the following medications, the Plan allows you to receive multiple refills at your local Participating Retail Pharmacy:

- Anti-infectives, including antibiotics (Amoxicillin, Biaxin), antivirals (Zovirax, Famvir), antifungals (Diflucan), and drops used in the eyes and ears (Polsporin Opth, Cipro Otic). Please note that drops must be prescribed specifically to treat infection.
- Prescription cough medications, including Phenergan with Codeine, Tessalon and Tussionex.
- Medications to treat acute pain, both narcotic (Vicodin, Percodan, etc.) and non-narcotic (Darvocet). Please note that long-term pain medications, such as NSAIDs, do not meet the necessary retail requirements.
- Medications that require a new written prescription each time you need them because refills are prohibited by federal law (e.g., Percodan, Ritalin and Nembutal).
- Medications used to treat both attention deficit disorder (Ritalin, Cylert) and narcolepsy (Dexedrine).
- Medications whose sole use is treating cancer.

To order medications from the Medco Pharmacy, log on to the Medco website (**www.medco.com**) or the HealthFlex/WebMD website (**www.gbophb.org**) to request that the Pharmacist contact your Physician (to order prescriptions, you must be a registered member of the Medco website for security reasons). You will need to confirm your information and provide the contact information for your Physician. If you prefer, you can have your Physician call **1-888-327-9791** for instructions on how to fax your prescription to Medco. You will receive

your medication in approximately 7 to 10 days. If you have a written prescription to mail, you will need to complete an order form (available from the Medco website or by calling Medco's member services department at **1-800-847-2806**) to include with your prescription. The prescription and order form should be mailed to the address provided on the form.

Once you have initiated your prescription delivery through the Medco Pharmacy, you can request refills online or via the member services department. Refills requested by Noon Eastern time are filled and shipped the same day.

COORDINATION WITH OTHER PRESCRIPTION DRUG COVERAGE

If you or your Dependents have Prescription Drug coverage through HealthFlex and through another group health plan or other insurance, Medco *will not* coordinate its payment for Prescription Drugs or Prescription Drug related expenses with those of the other group health plan or insurance. Therefore, at the time you place an order (make a claim) for Prescription Drugs (retail or by mail-order service) and you use the HealthFlex benefit, i.e., by presenting your HealthFlex ID Card or entering your HealthFlex ID Card number, Medco will pay for the Prescription Drug Claim as the Primary Plan. If you submit a claim for Prescription Drugs or related expenses paid by other group health plan or insurance, Medco *will not pay any further benefits* for such Prescription Drug Claim costs.

DRUG UTILIZATION REVIEW (DUR)

When you have your prescription filled, the Pharmacist and Medco may access information about previous prescriptions electronically and check Pharmacy records for Prescription Drugs that conflict or interact with the medicine then being dispensed. If there is a question, the Pharmacist will work with you and your Physician before dispensing the medication. This is an automatic feature available only with prescriptions purchased through a Participating Retail Pharmacy and the Medco Pharmacy.

SPECIAL PRESCRIPTION PROGRAM SERVICES EMERGENCY PHARMACIST CONSULTATION
Access to Pharmacists is available 24 hours a day, 7 days a week, for emergency consultation.

PHARMACY LOCATOR
A voice-activated system for locating Participating Retail Pharmacies within specific zip codes is available; call the member services department at **1-800-841-2806**.

This information is also available via the Medco website at **www.medco.com**.

TELECOMMUNICATIONS FOR THE DEAF
Call **1-800-759-1089**. Service is available Sunday through Friday, from 8:00 a.m. to midnight Eastern time, and on Saturday, from 8:00 a.m. to 6:00 p.m. Eastern time.

PRINTED MATERIALS FOR THE VISUALLY IMPAIRED
Large-print or Braille labels are available upon request for prescriptions purchased through the Medco Pharmacy.

PRESCRIPTION DRUG APPEALS
If your Claim for Prescription Drug Benefits has been denied in whole or in part, you may have your Claim reviewed. Medco will review its decision in accordance with the following procedure. Within 180 days after you receive notice of a denial or partial denial, write to Medco. Medco will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

Medco
8111 Royal Ridge Parkway
Irving, TX 75063
Attention: Admin Review

You may also designate a representative to act for you in the appeal. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial. Medco will generally give you a written decision within 60 days after it receives your request for review.

In accordance with the Patient Protection and Affordable Care Act (PPACA), because the Plan is not a “grandfathered plan” you have additional rights to appeal claims. Medco will follow the terms of the PPACA and the regulations issued by the Department of Health and Human Services implementing the PPACA regarding Claims for Prescription Drug Benefits, appeals and external reviews.

If you have filed a Claim for Prescription Drug benefits and have asked Medco to review your Claim, if it was initially denied, in whole or in part, and your Claim has been denied, in whole or in part, upon appeal, you may, only upon exhaustion of these administrative remedies, file suit in state or federal court.

General Limitations for Medical and Prescription Drug Benefits

No payment for medical benefits or Prescription Drug benefits will be made for expenses incurred for you or any of your Dependents:

- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- For Charges made by a Hospital owned or operated by or which provides care or performs Services for the United States Government: a) unless there is a legal obligation to pay such Charges whether or not there is coverage; or b) if such Charges are directly related to a military-service-connected Sickness or Injury.
- To the extent that payment is unlawful where the person resides when the expenses are incurred.
- For Charges that would not have been made if the person had no coverage.
- To the extent that they are more than the reasonable and customary Charge or Allowable Amount.
- For Charges that are not Eligible Expenses as determined by the Claims Administrator.
- For or in connection with Custodial Services, education or training.
- To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- For Charges made by a Physician for or in connection with Surgery which exceed the following maximum when two or more surgical procedures are performed at one time: the maximum amount payable will be the amount otherwise payable for the most expensive procedure, and 1/2 (one-half) of the amount otherwise payable for all other surgical procedures.
- For Charges made by an assistant surgeon in excess of 20 percent (20%) of the surgeon's allowable charge; or for Charges made by a co-surgeon in excess of the surgeon's allowable charge plus 20 percent (20%). For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to Co-insurance or Deductible amounts.
- For Charges made for or in connection with the purchase or replacement of contact lenses or eyeglasses except as specifically provided under *Covered Services*; however, the purchase of the first pair of contact lenses or eyeglasses that follows cataract surgery will be covered.
- For Charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.
- For Charges for supplies, care, treatment or Surgery that are not considered Eligible Expenses, as determined by the Claims Administrator.
- For Charges made for or in connection with tired, weak or strained feet for which treatment consists of routine foot care, including but not limited to, the removal of calluses and corns or the trimming of nails, unless considered Eligible Expenses by the Claims Administrator.
- For or in connection with speech therapy, if such therapy is: a) used to improve speech skills that have not fully developed; b) can be considered custodial or educational; or c) is intended to maintain speech communication; speech therapy which is not restorative in nature will not be covered.
- For Charges made by any Provider who is a member of your family or your Dependent's family. For Charges made by any Provider who shares the same legal residence as you.
- For Experimental, Investigational or Unproven Services which are medical, surgical, psychiatric, substance abuse or other healthcare technologies, supplies, treatments,

procedures, drug therapies or devices that are determined by the Claims Administrator, to be:

- not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional journal;
- the subject of review or approval by an Institutional Review Board for the proposed use;
- the subject of an ongoing clinical trial that meets the definition of a phase I, II, or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight; or
- not demonstrated, through existing peer-reviewed literature, to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

- For or in connection with an Injury or Sickness which is due to war, declared or undeclared.
- For expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the Charges are incurred while traveling on business or for pleasure.
- For nonmedical ancillary services, including but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety and Services, training or educational therapy for learning disabilities, developmental delays, autism or mental retardation.
- For medical treatment for a person age 65 or older, who is covered under this Plan as a working retiree, or their age 65 or older Dependent, when payment is denied by the Medicare plan because treatment was received from a Non-Network Provider.
- For medical treatment when payment is denied by a Primary Plan (including Medicare) (see: *Coordination of Benefits*) because treatment was received from a Provider that is not a network or participating Provider in the Primary Plan's network.
- For Charges that you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this Plan.
- For medical and Hospital care and costs for the infant child of a Dependent, the first 30 days and delivery is covered (unless that infant child is otherwise eligible under the Plan).

Coordination of Benefits for Medical Claims

Coordination of Benefits (COB) applies when you have health care coverage through more than one group plan or program. The purpose of COB is to ensure that there is not a duplication of benefit payments. In other words, the total payment from this Plan as a secondary payer (as a Secondary Plan) will not, when added to the benefit paid by the primary plan (the Primary Plan), exceed what this Plan would have paid if it were the Primary Plan. It is your obligation to notify the Claims Administrator of the existence of such other group coverages. See the *HealthFlex Summary Plan Description* for more information regarding COB.

Note: The coordination of benefits rules described in this section only apply to claims for medical benefits. The Program does not pay secondary benefits for Prescription Drug Claims. See the section entitled *Coordination With Other Prescription Drug Coverage*, above, for more information. For coordination of benefits rules related to mental health benefits or dental benefits, please review the applicable benefit booklet or certificate of insurance for those benefits. For coordination of benefits rules related to vision benefits, please contact Vision Service Plan (VSP) at the number listed in the *Vision Benefits* section of this Benefit Booklet.

Limitations of Actions

You cannot bring any legal action against the Plan, the General Board or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in *How to File a Medical Claim* and all required reviews of your claim have been completed (i.e., you have exhausted your administrative remedies). If you want to bring a legal action against the Plan, the General Board or the Claims Administrator, you must do so within 3 years from the expiration of the time period in which a request for reimbursement must have been submitted or you lose any rights to bring such an action against the Plan, the General Board or the Claims Administrator.

You cannot bring any legal action against the Plan, the General Board or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this Benefit Booklet. After completing that appeal process, if you want to bring a legal action against the Plan, the General Board or the Claims Administrator, you must do so within3 years of the date you are notified of our final decision on your appeal or you lose any rights to bring such an action against the Plan, the General Board or the Claims Administrator.

Information and Records

You agree that it is your personal responsibility to ensure that any Provider, insurance company, employee benefit association, government body or program, or any other person or entity, having knowledge of records relating to: a) any Sickness or Injury for which a Claim or Claims for benefits are made under the Plan; or b) any medical history which may be pertinent to such Claim or Claims, furnish to the Claims Administrator or its agent, and agree that any such Provider, person or entity may furnish to the Claims Administrator or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such Sickness, Injury, Claim or Claims. In addition, the Claims Administrator may furnish similar

information and records (or copies of records) to Providers, insurance companies, governmental bodies or programs, or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish the Claims Administrator, your Plan Sponsor and the General Board information regarding you or your Dependents becoming eligible for Medicare, termination of Medicare eligibility, or any changes in Medicare eligibility status in order that the Claims Administrator will be able to make Claim Payments in accordance with Medicare Secondary Payer (MSP) laws.

PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

- Under this Plan, the Claims Administrator has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, the Claims Administrator may pay benefits to you if you receive Covered Services from a Non-Network Provider. The Claims Administrator is specifically authorized by you to determine to whom any benefit payment should be made.
- Once Covered Services are rendered by a Provider, you have no right to request the Claims Administrator not to pay the Claims submitted by such Provider and no such request will be given effect, except in situations where a Covered Person's request for nonpayment is because Services have not been rendered as described in the Claim. In addition, the Claims Administrator will have no liability to you or any other person because of its rejection of such request.
- A Covered Person's Claim for benefits under this Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at any time before or after Covered Services are rendered to a Participant. Coverage under this Health Care Plan is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

YOUR PROVIDER RELATIONSHIPS

- The choice of a Provider is solely your choice, and the Claims Administrator will not interfere with your relationship with any Provider.
- Neither the Plan, General Board, nor the Claims Administrator undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. The Claims Administrator, Plan and General Board are not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services that can only be legally performed by a Provider are not provided by the Claims Administrator, the Plan or the General Board. Any contractual relationship between a Physician and an Administrator Provider shall not be construed to mean that the Claims Administrator is providing professional service.
- The use of an adjective such as Network, Administrator or approved in modifying a Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of Network, Administrator, approved or any similar modifier or the use of a term such as Non-Administrator or Non-Network should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.

- Each Provider provides Covered Services only to you and does not deal with or provide any Services to your employer or Plan Sponsor (other than as an individual Participant) or the General Board's Health Benefit Program.

Network Providers have signed an Agreement with the Claims Administrator to accept an agreed-upon Charge as payment in full. Such Network Providers have agreed not to bill you for Covered Services amounts in excess of the agreed upon Charge. Therefore you will be responsible only for the difference between the Claims Administrator's benefit payment and the agreed-upon Charge for the particular Covered Service—that is, your program Deductible and Co-payment amounts.

Non-Network Providers have not signed an agreement with the Claims Administrator to accept the agreed-upon Charge as payment in full. Therefore, you are responsible to these Providers for the difference between the Claims Administrator's benefit payment and such Provider's charge to you.

OVERPAYMENTS
If the Plan pays benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Claims Administrator or Plan 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, and/or
- All or some of the payment made by the Plan exceeded the benefits provided under the Plan.

The refund due will equal the amount paid by the Plan in excess of the amount the Plan should have paid under its terms. If the refund is due from another person or organization, the Covered Person agrees to help the Claims Administrator and the Plan obtain the refund when requested.

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

REBATES AND OTHER PAYMENTS
The Plan and the Claims Administrator may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. The Plan and the Claims Administrator do not pass these rebates on to you, nor are they taken into account in determining your Co-payments.

ADMINISTRATIVE SERVICES
The Plan and Claims Administrator may, in their 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 the sole discretion of the Plan and Claims Administrator. The Plan and Claims Administrator are not required to give you prior notice of any such change, nor obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Your Other HealthFlex Benefits

MENTAL AND BEHAVIORAL HEALTH BENEFITS

The Plan provides mental and behavioral health benefits for Participants through United Behavioral Health (UBH). The Claims Administrator for medical benefits (UHC) does not administer Claims for mental and behavioral health benefits. UBH is responsible for all administration, utilization review and case management of your mental health and behavioral health benefits. Claims for mental health benefits should be submitted to UBH, not the Claims Administrators for medical or Prescription Drug benefits. In addition, through UBH, the Plan maintains an Employee Assistance Program (EAP) for your use in dealing with such matters as family counseling, financial advice, legal assistance and the like. UBH customer service coordinators are available to answer questions about your mental health benefits 24 hours per day, 7 days per week.

The terms and conditions of your mental health benefits are governed by the agreements between UBH and the Plan Administrator. You can find out more about your behavioral health benefits at the UBH website at **www.liveandworkwell.com/member** or through the HealthFlex/WebMD website at **www.gbophb.org**. You may also review the benefit summary for the Employee Assistance Program and Mental Health Benefits (available on the General Board's HealthFlex/WebMD website at **www.gbophb.org**) for more information.

Required Review Procedures

Participants should consider calling the UBH toll-free number (**1-800-788-5614**) before any Inpatient mental health and substance abuse treatment. Benefits are subject to retrospective review for medical necessity if not pre-authorized by UBH. When you call you should provide the following: the name of the covered Employee and the name of the patient; the name, address and telephone number of the Hospital; and the scheduled date of admission. If you do not have a mental health or behavioral health Provider and need assistance in selecting one, UBH can assist you with a referral. For emergency admissions (including evenings and weekends), you or your Provider must contact UBH customer service at the time of the admission.

Reduced Benefits for Failure to Follow Required Review Procedures

The Plan provides significantly reduced benefits for any Inpatient and other mental health services that have not been pre-authorized through UBH. Your benefits will be reduced and you may be penalized for expenses incurred for services that have not been pre-authorized by UBH. Pre-authorization, however, is not a guarantee of benefits.

DENTAL BENEFITS

Dental benefits are available under the Plan to eligible Participants whose Plan Sponsors have elected to provide dental benefits through an Adoption Agreement. Please contact your Plan Sponsor with questions regarding the availability of dental benefits for you. You may also contact the General Board regarding eligibility and other dental benefits questions. Connecticut General Life Insurance Company (CIGNA) is the Claims Administrator for dental benefits under the Plan. CIGNA administers utilization, review, benefit payment and case management of your dental benefits. Claims for dental benefits should be submitted to CIGNA, not to the Claims Administrators for medical or Prescription Drug benefits.

A detailed description of your dental benefits can be found in the HealthFlex Dental Benefits Booklet, available online at the General Board's HealthFlex/WebMD website at **www.gbophb.org**.

CIGNA customer service coordinators are available at **1-800-CIGNA-24** (**1-800-244-6224**) to answer questions about your dental benefits 7 days a week 24 hours a day (including holidays). If you are calling due to a dental emergency, follow the directions as instructed on the CIGNA voice response system. You can also find information about your dental benefits online at **www.cigna.com**.

VISION BENEFITS

The Plan provides your vision benefits through Vision Service Plan Insurance Company (VSP). VSP is the Claims Administrator for vision benefits under the Plan. Any Claim for vision benefits should be submitted to VSP, not the Claims Administrators for medical or Prescription Drug benefits. For more complete information regarding your vision coverage, you should consult the materials provided by VSP.

To find out more about your vision benefits under the Plan or to find a Participating Provider of vision benefit services you may call VSP at **1-800-977-7195** or **visit www.vsp.com**.

Benefit Options

Depending on the choices your Plan Sponsor has elected on its Adoption Agreement, you may or may not be eligible for the vision material benefits. Please contact your Plan Sponsor if you have questions regarding the availability of vision material benefits to you. Your Plan Sponsor may choose different levels of coverage for vision benefits for its Participants. Plan Sponsors may choose to provide Participants with: 1) a full coverage option; 2) an exam core option; or 3) the incentive materials option. Please contact your Plan Sponsor if you have questions about which option you may be covered under, if any.

Covered Vision Benefits

When all of the provisions of this Plan are satisfied, the Plan will provide benefits as outlined below for the services and supplies listed in this section. This list is intended to give you a general description of expenses for services and supplies covered by the Plan. You may also consult the benefit summary of visions benefits available online at the General Board's HealthFlex/WebMD website (**www.gbophb.org**).

Benefits at a Participating VSP Provider

Exam Core Option

- Vision examinations by a Physician or Provider, limited to one every 12 months paid in full. Benefits include: case history, visual acuity (clearness of vision), external examination and measurement; interior examination with ophthalmoscope; pupillary reflexes and eye movements; retinoscopy (shadow test); subjective refraction; coordination measure (far and near); medicating agents for diagnostic purposes; tonometry (glaucoma test) in connection with a vision examination; and analysis of findings with recommendations and prescription if required. *You will be required to pay a $20.00 Co-payment.* Your benefit will be limited to a $50.00 reimbursement if you have your vision exam performed by a Provider that is not a VSP Participating Provider.

- In addition to the benefits described above, through your relationship with VSP under the Plan, certain extra discounts on vision services and materials are available to you. These are not benefits paid by the Plan, but rather they are savings available to you on Out-of-Pocket expenses for vision services. Such Out-of-Pocket expenses may be eligible for reimbursement through a flexible spending account for health care expenses.
  - Laser vision correction discounts at VSP participating facilities.
  - 20% discount toward prescribed lenses when a complete pair of glasses is purchased,
  - 20% discount toward frames when a complete pair of glasses is purchased,
  - 15% discount on fitting and evaluation exams for contact lenses,
  - Exclusive pricing on contact lenses and supplies, and
  - 20% discount toward additional pairs of glasses or sunglasses, including lens options.

Full-Service Option or Incentive Materials Option

- Vision examinations by a Physician or Provider, limited to one every 12 months paid in full. *You will be required to pay a $20.00 Co-payment.* Your benefit will be limited to a $50.00 reimbursement if you have your vision exam performed by a Provider that is not a VSP Participating Provider.
- Glass or plastic lenses prescribed by a Physician or Provider, limited to one pair every 12 months. Benefits include: single vision, lined bifocal and lined trifocal lenses. *You will be required to pay a $20.00 Co-payment.* Your benefit will be limited to a reimbursement of: 1) $50.00 for single vision lenses, 2) $75.00 for bifocal lenses, 3) $100.00 for trifocal lenses if you purchase your glasses through a Provider that is not a VSP Participating Provider.
- Frames to hold prescribed lenses, limited to one pair every 24 months. Benefits include frames of your choice up to $120.00 with a discount of 20% off any Out-of-Pocket expenses (e.g., frames cost beyond $120.00). Your benefit will be limited to a $70.00 reimbursement if you purchase your glasses through a Provider that is not a VSP Participating Provider.
- Contact lenses benefits include: contact lenses and fitting evaluation exam up to $120.00 in place of lenses and frames, whether medically appropriate or as an elective alternative to conventional lenses. *No Co-payment is required for contact lenses.* Your benefit will be limited to a $105.00 reimbursement if you purchase your contact lenses through a Provider that is not a VSP Participating Provider.
- In addition to the benefits described above, through your relationship with VSP under the Plan, certain extra discounts on vision services and materials are available to you. These are not benefits paid by the Plan, but rather they are savings available to you on Out-of-Pocket expenses for vision services. Such Out-of-Pocket expenses may be eligible for reimbursement through a flexible spending account for health care expenses.
  - Laser vision correction discounts at VSP Participating Providers.
  - Up to 40% discount savings on lens extras such as scratch resistant and anti-reflective coatings and progressives.
  - 20% discount toward the purchase of additional prescription glasses and sunglasses at VSP Participating Providers.
  - Exclusive pricing on annual supplies of popular brands of contact lenses.
  - 15% discount on the cost of contact lens exams (fitting and evaluation).

Co-payments and Out-of-Pocket expenses for vision benefits do not apply toward the satisfaction of your Deductible or Out-of-Pocket Maximum for medical benefits. Co-payments and Out-of-Pocket expenses for vision benefits may, however, be reimbursable through a flexible spending account for health care expenses.

Vision Expenses Limitations (Options Available at Additional Cost)
The VSP Plan is designed to provide your basic eyewear needs. It does not cover items that are considered cosmetic or elective. The following options will require an additional charge over the covered benefit. You must pay these additional charges directly to the Provider. The extra charges may be eligible for reimbursement through a flexible spending account.

Examples:
- Blended (no-line) bifocal,
- Progressive power multifocal lenses,
- Polished bevels and faceted lenses,
- Scratch coating, UV coating, anti-reflective coating,
- Slab-off lenses,
- Polycarbonate, polaroid, photochromic lenses,
- Oversized lenses (larger than 62 mm),
- Prism lenses,
- Cosmetic lenses, and
- Tints on lenses.

Vision Expenses Not Covered
No benefits are available for the following products and services:
- Replacement frames and lenses except at normal intervals when services are otherwise available;
- Non-prescription sunglasses;
- Orthoptics, vision training or any associated supplemental testing;
- Frame cases;
- Low (subnormal) vision aids;
- Eye exams required by an employer as a condition of employment;
- Services and materials provided by another vision plan;
- Any condition or disability sustained as a result of being engaged in an activity primarily for wage, profit or gain, and that could entitle the covered person to a benefit under the Workers' Compensation Act or similar legislation;
- Benefits provided under any Participant's medical coverage;
- Medical or surgical treatment of the eyes; and
- Circumstances described in the section of this Benefit Booklet titled *General Limitations for Medical and Prescription Drug Benefits*.

Other Important Provisions

PHYSICIAN/PATIENT RELATIONSHIP

The Plan is not intended to disturb the Physician/patient relationship. Physicians and Other Health Care Providers are not agents or delegates of any employer, Plan Sponsor, the General Board or the Claims Administrator. Nothing contained in this Benefit Booklet or the Plan will require you or your Dependent to commence or continue medical treatment by a particular Provider. Furthermore, nothing in this Benefit Booklet or the Plan will limit or otherwise restrict a Physician's judgment with respect to the Physician's ultimate responsibility for patient care in the provision of medical services to you or your Dependent.

RIGHT TO AMEND OR TERMINATE PLAN

The General Board reserves the right to amend, modify or terminate the Plan in any manner, for any reason, at any time without prior notification.

YOUR RIGHTS

If you have any questions about your rights under HIPAA or the PPACA, you should contact the appropriate department of the U.S. Department of Health and Human Services. For primarily *HIPAA* concerns: contact the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHS Building, Washington, D.C. 20201. For *PPACA* concerns, contact the Center for Consumer Information and Oversight, U.S. Department of Health and Human Services, 200 Independence Ave. SW, Washington, D.C. 20201.

PLAN'S STATUS AS A CHURCH PLAN

Use of the terms Co-insurance, Co-payment, Deductible and premium in this Benefit Booklet do not imply that either UnitedHealthcare Insurance Company or Medco insure the Plan. Similarly, use of such terms does not imply that the Plan or the General Board are in the business of insurance. The Plan is offered by the General Board as a self-funded Church Plan only for the benefit of eligible clergy and Employees, and their families, of organizations affiliated with the General Board through The United Methodist Church. UnitedHealthcare Insurance Company and Medco are merely third-party administrators in a contractual relationship with the Plan and the General Board who are not financially responsible for any benefits paid under the Plan.

Though Church Plans are considered employee welfare benefit plans under Section 3(1) of ERISA, as indicated by Section 4(b)(2) of ERISA, Title I of ERISA does not apply to Church Plans. Therefore, most regulations issued by the U.S. Department of Labor do not govern the administration of the Plan. In addition, Church Plans are exempt from most state laws regulating insurers, such as state insurance licensing, solvency and funding requirements, by the Church Plan Parity and Entanglement Protection Act of 2000 (Parity Act). Self-insured Church Plans are also not subject to many other state laws and regulations that govern insurers because the Parity Act, along with certain state laws with respect to Church Plans, may remove such Plans from state insurance regulations.

Termination of Coverage and Continuation Coverage

You will no longer be entitled to the health care benefits described in this Benefit Booklet if either of the events stated below should occur:

- If you no longer meet the previously stated description of an Eligible Person; or
- If the Plan of the General Board terminates.

Further, termination of the Administrative Services Agreement (Agreement) between the Claims Administrator and the General Board automatically terminates your coverage as described in this Benefit Booklet. It is the responsibility of the General Board to notify you in the event the Agreement is terminated with the Claims Administrator. Regardless of whether such notice is provided, your coverage will terminate as of the effective date of termination of the General Board's Agreement with the Claims Administrator.

No benefits are available to you for Services or supplies rendered after the date of termination of your coverage under the Plan described in this Benefit Booklet except as otherwise specifically stated in the *Continuation Coverage* provisions of the *HealthFlex Summary Plan Description*. However, termination of the General Board's Agreement with the Claims Administrator and termination of your coverage under the Plan shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

Unless specifically mentioned elsewhere in this Benefit Booklet, if one of your Dependents becomes ineligible, his or her coverage will end as of the date the event occurs which makes him or her ineligible (e.g., date of divorce, date the limiting age is reached).

Please refer to the *HealthFlex Summary Plan Description* for additional information regarding termination of coverage and continuation coverage.

Requirements of Family and Medical Leave Act of 1993

Your Plan Sponsor, Conference or the General Board will give you detailed information about the Family and Medical Leave Act of 1993 upon request. You may also refer to the *HealthFlex Summary Plan Description* for information.

Definitions

ACTIVE SERVICE
You will be considered in Active Service:

- On any of your employer's or Conference's scheduled work days if you are performing the regular duties of your work on a permanent basis, and you are regularly scheduled to work 30 hours per week or more, on that day either at your employer's or Conference's place of business or at some location to which you are required to travel for your employer's or Conference's business;
- On a day which is not one of your employer's, or Conference's scheduled work days if you were in Active Service on the preceding scheduled work day.

ACUPUNCTURE
The term Acupuncture refers to the traditional Chinese practice of puncturing the body with needles at specific points to cure disease or relieve pain.

AFFILIATED ORGANIZATION
The term Affiliated Organization means any of the organizations and corporations associated with the General Board through The United Methodist Church, as described in Section 414(e) of the Code and which is a participating organization in the Plan.

ALLOWABLE AMOUNT
The term Allowable Amount means the amount that the Plan will pay for Prescription Drugs based upon pricing at a Participating Retail Pharmacy.

ALTERNATE FACILITY
The term Alternate Facility means 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, and
- Pre-scheduled rehabilitative, laboratory or diagnostic services.

AMENDMENT
The term Amendment means any attached written description of additional Covered Services not described in this Benefit Booklet. Amendments are subject to all conditions, limitations and exclusions of the Plan except for those that are specifically amended in the Amendment.

BED AND BOARD
The term Bed and Board includes all Charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

THE BOOK OF DISCIPLINE
The term *The Book of Discipline* means the body of church law established by the General Conference of The United Methodist Church, as amended from time to time.

BRAND NAME DRUG
The term Brand Name Drug means a single source or brand version of a multi-source brand drug set forth in First Databank's National Drug Data File or such other nationally recognized source, as reasonably determined by Medco.

CALENDAR YEAR
The term Calendar Year means a 12-month period beginning on January 1 and each 12-month period thereafter.

CARE COORDINATION[SM]
The term Care Coordination[SM] (or Care Coordinator) refers to a program provided by the Claims Administrator designed to encourage an efficient system of care for Covered Persons by identifying and addressing possible unmet covered health care needs.

CHANGE IN STATUS EVENT
The term Change in Status Event refers to a change in coverage due to the following changes in status:

- Change in legal marital status due to marriage, death of a Spouse, divorce, annulment or legal separation;
- Change in number of Dependents due to birth, adoption, placement for adoption or death of a Dependent;
- Change in employment status of Participant, Spouse or Dependent due to termination or start of employment (**Note:** Appointment changes for clergy Employees are not considered Change in Status Events under the Plan);
- Changes in employment status of the Participant, Spouse or Dependent resulting in eligibility or ineligibility for coverage;
- Changes that cause a Dependent to become eligible or ineligible for coverage. Any changes in coverage must be consistent with the Change in Status Event; and
- Significant changes in coverage such as the loss or change of a benefit option resulting from a move to a new zip code.

CHARGES
The term Charges means the actual billed Charges, except when the Provider has contracted directly or indirectly with the Claims Administrator for a different amount.

CHURCH PLAN
A Church Plan is an employee benefit plan established and maintained for its employees by a church or by a convention or association of churches, as established in Section 414(e) of the Code and Section 3(33) of ERISA.

CLAIM
The term Claim means notification in a form acceptable to the Claims Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge and any other information which the Claims Administrator may request in connection with Services rendered to you.

CLAIMS ADMINISTRATOR
For medical and hospitalization services provided under the terms of this Benefit Booklet and the Plan, the term Claims Administrator means UnitedHealthcare Insurance Company. For administration of Prescription Drug benefits provided by the Plan under the terms of this Benefit Booklet, the Claims Administrator is Medco.

CLAIM CHARGE
The term Claim Charge means the amount that appears on a Claim as the Provider's charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between the Claims Administrator and a particular Provider.

CLAIM PAYMENT
The term Claim Payment means the benefit payment calculated by the Claims Administrator, after submission of a Claim, in accordance with the benefits described in this Benefit Booklet. All Claim Payments will be calculated on the basis of the eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between the Claims Administrator and a particular Provider.

CODE
The term Code means the Internal Revenue Code of 1986, as amended.

CONFERENCE
The term Conference means an Annual Conference, Provisional Conference or Missionary Conference of The United Methodist Church that is located in a Jurisdictional Conference in the U.S. as such entities are defined in *The Book of Discipline*.

CONGENITAL ANOMALY
This term refers to a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

CO-INSURANCE
Co-insurance percentages represent the portion of Charges for Covered Services paid by you and the Plan after satisfaction of any applicable Deductible. These percentages apply only to Charges for Covered Services that do not exceed the Maximum Allowance. You are responsible for all noncovered expenses, including any amount that exceeds the Maximum Allowance for Covered Services.

Note: Use of the term "Co-insurance" in this Benefit Booklet does not imply that either UnitedHealthcare or Medco insure the Plan. The Plan is offered by the General Board on a self-funded basis. UnitedHealthcare and Medco act as the third-party contract administrators and are not financially responsible for any benefits paid under the Plan. The Co-insurance amounts are shown on The Schedule of Medical Benefits.

CONSUMER-DRIVEN HEALTH PLAN (CDHP)
CDHP refers to a Benefit Option under the Plan that is a consumer-driven health plan (CDHP), also called high deductible health coverage (sometime referred to as a high deductible health plan, although it is technically not a high deductible health plan under the Code). The CDHP is designed to drive participants' behavior toward informed medical decision-making and carries higher deductibles and out-of-pocket limits than the PPO Benefit Options under the Plan. The

CDHP is generally accompanied by an HRA, which provides Plan Sponsor- and Plan-provided financial assistance toward satisfying those higher deductibles.

COORDINATED HOME CARE PROGRAM
The term Coordinated Home Care Program means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes Skilled Nursing Service by a registered professional Nurse, the services of physical, occupational and speech therapists, Hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

CO-PAYMENT
Co-payment, sometimes called a "co-pay," means the first-dollar amount you must pay for certain Covered Services under the Plan that is usually paid at the time the service is performed (e.g., Physician office visits or emergency room visits). Co-payments do not apply to your annual Deductible, but co-payments do apply to your annual Out-of-Pocket Maximum. The Co-payment amounts are shown on The Schedule of Medical Benefits.

COSMETIC PROCEDURES
The term Cosmetic Procedures means procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

COST EFFECTIVE
The least expensive equipment or procedure that performs the necessary function or treatment.

COVERAGE DATE
The term Coverage Date means the date on which your coverage under the Plan begins.

COVERED PERSON
The term Covered Person means either the Primary Participant or an Enrolled Dependent, but this term applies only while the person is enrolled under the Plan. References to "you" and "your" throughout this Benefit Booklet are references to a Covered Person (also called a Participant).

COVERED PRESCRIPTION DRUG
The term Covered Prescription Drug means a drug that, under state or federal law, requires a prescription, including compound prescriptions, and for which benefits will be provided under the Plan. Excluded from Covered Prescription Drugs are:

- Cosmetic drugs;
- Appliances, devices, bandages, heat lamps, braces, splints, and artificial appliances;
- Health and beauty aids, cosmetics and dietary supplements; and
- Over-the-counter (OTC) products.

COVERED SERVICE
The term Covered Service means a health service provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, mental illness, substance abuse or their symptoms. A Covered Service is a health care service or supply described in the section of this Benefit Booklet titled *Covered Services*, and that is not excluded under Services Not Covered, including Experimental or Investigational Services and Unproven Services.
Covered Services must be provided:

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

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

CUSTODIAL CARE
The term Custodial Care means 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);
- Are health-related services that 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.

CUSTODIAL SERVICES
The term Custodial Services means any services which are not intended primarily to treat a specific Injury or Sickness (including Mental Health and Substance Abuse). Custodial Services include, but shall not be limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods or taking medications that can usually be self-administered; and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

DEDUCTIBLE
The term Deductible means the amount of Charges for Covered Services each Covered Person must pay during each year before the Plan will consider expenses for reimbursement. The individual Deductible applies separately to each Covered Person. The family Deductible applies collectively to all Covered Persons in the same family. When the family Deductible is satisfied, no further Deductible will be applied for any covered family member during the remainder of that Plan Year; however, the Participant may be responsible for an Inpatient Hospital Deductible, certain specific benefit deductibles or costs beyond the Reasonable and Customary Charge even though the Participant has satisfied the individual or family Deductible. Deductible amounts are shown on *The Schedule of Medical Benefits*.

DEPENDENT
The term Dependent, for all Participants, regardless of a Participant's State of residence, means:

- Your lawful Spouse; and
- Any child of yours who is:
  - less than 26 years old; or
  - age 26 and older and:
    - an unmarried child who is mainly dependent on you for financial support and is currently a covered dependent as a result of Michelle's Law;[1] or
    - an unmarried child who is not self-supporting due to a physical or mental impairment.

A child includes one who is in the custody of the Participant, pursuant to an interim court order of adoption or placement for adoption, whichever comes first, whether or not a final order granting adoption is ultimately issued. It also includes a stepchild who lives with you. It also includes a child living with you for whom you are the legal guardian.

Benefits for a Dependent child will continue until the last day of the calendar month in which the limiting age is reached

No one may be considered as a Dependent of more than one Participant.

DESIGNATED UNITED RESOURCE NETWORK FACILITY
The term Designated United Resource Network Facility means a Hospital that the Claims Administrator names as a Designated United Resource Network Facility. A Designated United Resource Network Facility has entered into an agreement with the Claims Administrator to render Covered Services for the treatment of specified diseases or conditions. A Designated United Resource Network Facility may or may not be located within the Claims Administrator's geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated United Resource Network Facility.

DIAGNOSTIC SERVICE
The term Diagnostic Service means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or Injury. Such tests include, but are not limited to, X-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests and electromyograms.

[1] Michelle's Law applies to full-time students enrolled at a post-secondary institution who are covered under their parent's health insurance plan and take a medical leave due to a serious injury or illness. Under the law, a "medical leave" means that the student is absent from school or reduces his or her full-time course load to part-time.

ELIGIBLE EXPENSES
The term Eligible Expenses means expenses for Covered Services, incurred while the Plan is in effect, that are determined as stated below. Eligible Expenses are based on either of the following:

- When Covered Services are received from Network Providers, Eligible Expenses are the contracted fees with that Provider.
- When Covered Services are received from Non-Network Providers, unless you receive services as a result of an Emergency, Eligible Expenses are determined at the Claims Administrator's discretion by either (1) calculating Eligible Expenses based on available data resources of competitive fees in that geographic area; or (2) applying the negotiated rates agreed to by the Non-Network Provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors.

ELIGIBLE PERSON
The term Eligible Person means an employee of the General Board, employee of an Affiliated Organization, or other Participant of the Plan maintained by the General Board who meets the eligibility requirements for this health coverage, in accordance with the terms of the Plan as described in the *Eligibility* section of this Benefit Booklet.

EMERGENCY
Emergency is a situation where anyone with average knowledge of health and medicine who experiences acute symptoms, including severe pain, would reasonably believe that failing to obtain immediate medical attention could seriously jeopardize his or her health. This standard includes seriously impaired bodily functions, serious dysfunction of any bodily organ or part, and serious jeopardy to the health of an unborn child.

EMERGENCY HEALTH SERVICES
Emergency Health Services means medical screening exams including routinely available ancillary services, that a hospital emergency department is capable of performing to evaluate emergency medical conditions, as well as other exams and treatments available at and used by hospitals to stabilize patients with emergency medical conditions (as defined by the Emergency Medical Treatment and Labor Act).

EMPLOYEE
For purposes of this Benefit Booklet, the term Employee means a person who is described as an employee of a church in Sections 414(e)(3) or 7701(a)(20) of the Code, who is a clergyperson serving The United Methodist Church, or who is a common law employee of the General Board or an Affiliated Organization, including a former Employee who has retired.

ENROLLMENT PERIOD
The term Enrollment Period means the period specified by the Plan during which you may apply for coverage if you did not apply within 30 days of your Eligibility Date or Change in Status Event.

ENROLLED DEPENDENT
An Enrolled Dependent is a Dependent who is properly enrolled under the Plan.

ERISA
The term ERISA means the Employee Retirement Income Security Act of 1974, as amended.

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

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

If you have a life-threatening Sickness or condition (one which is likely to cause death within 1 year of the request for treatment) the Claims Administrator may, in its 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, 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.

FREE-STANDING SURGICAL FACILITY
The term Free-Standing Surgical Facility means an institution that meets all of the following requirements:

- It has a medical staff of Physicians, Nurses and licensed anesthesiologists,
- It maintains at least two operating rooms and one recovery room,
- It maintains diagnostic laboratory and X-ray facilities,
- It has equipment for emergency care,
- It has a blood supply,
- It maintains medical records,
- It has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an Inpatient basis, and
- It is licensed in accordance with the laws of the appropriate legally authorized agency.

FORMULARY
The term Formulary means the list of Generic Drugs and Brand Name Drugs that are preferred by the Plan. This list offers you choices while helping you and the Plan keep the cost of Prescription Drugs down.

GENERAL BOARD
The term General Board means the General Board of Pension and Health Benefits of The United Methodist Church, Incorporated in Illinois in its role as Plan Administrator.

GENERIC DRUG
Generic Drugs and their Brand Name Drug counterparts have the same active ingredients and are manufactured according to the same strict federal regulations. Generic Drugs may differ in color, size or shape from Brand Name Drugs, but the U.S. Food and Drug Administration requires that the active ingredients have the same strength, purity and quality as their Brand Name Drug counterparts. Generic Drugs may also be manufactured by either a single manufacturer or multiple manufacturers.

HEALTH REIMBURSEMENT ACCOUNT (HRA)
The Health Reimbursement Accounts are health reimbursement arrangements as described in *IRS Notice 2002-45*. HRAs are employer (i.e., Plan Sponsor and Plan)-funded accounts that help Participants covered in the CDHP Benefit Option satisfy higher deductibles and out-of-pocket expenses by reimbursing certain eligible medical expenses. HRAs do not include any Participant contributions. **Note**: A Plan Sponsor that has not adopted the CDHP Benefit Option may also choose to fund an HRA for its covered Participants.

HIPAA
The term HIPAA means the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder by the Secretary of the U.S. Department of Health and Human Services. HIPAA provisions help protect the privacy of Personal Health Information (PHI).

HOME HEALTH AGENCY
The term Home Health Agency means a program or organization authorized by law to provide health care Services in the home.

HOSPICE CARE PROGRAM
The term Hospice Care Program means:
- A coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- A program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness; and
- A program for persons who have a Terminal Illness and for the families of those persons.

HOSPICE CARE PROGRAM PROVIDER
The term Hospice Care Program Provider means an organization duly licensed to provide Hospice Care Program Service.

HOSPICE CARE PROGRAM SERVICE
The term Hospice Care Program Service means a centrally administered program designed to provide for the physical, psychological and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility or special hospice care unit.

HOSPICE CARE SERVICES
The term Hospice Care Services means any services provided by:
- Hospital,

- Skilled Nursing Facility or a similar institution,
- Home Health Care Agency,
- Hospice Facility, or
- Any other licensed facility or agency under a Hospice Care Program.

HOSPICE FACILITY
The term Hospice Facility means an institution or part of it which:
- Primarily provides care for Terminally Ill patients,
- Is accredited by the National Hospice Organization,
- Meets standards established by the Claims Administrator, and
- Fulfills any licensing requirements of the state or locality in which it operates.

HOSPITAL
The term Hospital means:
- An institution licensed as a Hospital, which: a) maintains, on the premises, all facilities necessary for medical and surgical treatment; b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and c) provides 24-hour service by Registered Graduate Nurses.
- An institution which qualifies as a Hospital, a psychiatric Hospital or a tuberculosis Hospital, and a Provider of Services under Medicare, if such institution is accredited as a Hospital by the Joint Commission on the Accreditation of Hospitals (The Joint Commission); or
- An institution which: a) specializes in treatment of Mental Health and Substance Abuse or other related illness; b) provides residential treatment programs; and c) is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital does not include an institution that is primarily a place for rest, a place for the aged or a nursing home.

HOSPITAL CONFINEMENT OR CONFINED IN A HOSPITAL
A person will be considered Confined in a Hospital if he or she is a registered bed patient in a Hospital upon the recommendation of a Physician.

ID CARD
The term ID Card means the identification card that contains your Participant information issued to you by the Claims Administrator.

INITIAL ENROLLMENT PERIOD
The term Initial Enrollment Period means 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
The term Injury means an accidental bodily injury.

INPATIENT
The term Inpatient means that you are a registered bed patient and are treated as such in a health care facility.

INPATIENT REHABILITATION FACILITY
The term Inpatient Rehabilitation Facility means 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 or speech therapy) on an inpatient basis, as authorized by law.

INPATIENT STAY
The term Inpatient Stay means an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

MAINTENANCE TREATMENT
The term Maintenance Treatment means treatment rendered to keep or maintain the patient's current health status.

MANIPULATIVE THERAPY SERVICES
The term Manipulative Therapy Services means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

MAXIMUM ALLOWANCE
The term Maximum Allowance means the amount determined by the Claims Administrator that Participating Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Providers, whether Network or Non–Network, will be based on The Schedule of Maximum Allowances. These amounts may be amended from time to time by the Claims Administrator.

MEDCO PHARMACY
The term Medco Pharmacy means the pharmacy program in which Participants may submit a maintenance (long-term) prescription along with the applicable Co-payment to Medco for dispensing via Medco's mail-order service, e.g., ordered online, by phone or by mail and delivered to the participant through the U.S. Postal Service or commercial delivery courier.

MEDICAID
The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965, as amended.

MEDICARE
The term Medicare means the federal program of medical care benefits for persons age 65 and older and for certain persons under age 65 who are disabled, provided under Title XVIII of the Social Security Act of 1965, as amended.

MEDICARE APPROVED OR MEDICARE PARTICIPATING
The term Medicare Approved or Medicare Participating means a Provider that has been certified or approved by the Department of Health and Human Services for participating in the Medicare program.

MEDICARE SECONDARY PAYER (MSP)
The term Medicare Secondary Payer means those provisions of the Social Security Act set forth in 42 U.S.C. w1395 y (b), and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare–eligible employees, their Spouses and, in some cases, Dependent children.

MEDICALLY NECESSARY/MEDICAL NECESSITY
The term Medically Necessary/Medical Necessity means health care services and supplies that are determined by the Claims Administrator to be:

- Required to meet your essential health needs;
- Consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research;
- Required for purposes other than the convenience of the Provider or the comfort and convenience of the patient; and
- Rendered in the least intensive setting that is appropriate for the delivery of health care.

MULTI-SOURCE
The term Multi-source refers to a Brand Name Drug that has a Generic Drug equivalent. A Multi-source medication may be manufactured by either a single producer or multiple producers.

NAPRAPATH
The term Naprapath means a therapist who practices Naprapathy and who is duly licensed by a state licensing authority in states where such licensing is required.

NAPRAPATHY
The term Naprapathy means the treatment of disease by manipulation of joints, muscles and ligaments, based on the belief that many diseases are caused by displacement of connective tissues.

NAPRAPATHIC SERVICES
The term Naprapathic Services means the performance of naprapathic practice by a Naprapath that may legally be rendered by them.

NECESSARY SERVICES AND SUPPLIES
The term Necessary Services and Supplies includes:

- Any Charges, except Charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement;
- Any Charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and
- Any Charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any Charges for special nursing fees, dental fees or medical fees.

NETWORK
The term Network, when used to describe a Provider of health care services, 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 Services to Covered Persons. A Provider may enter into an agreement to provide only certain Covered Services, but not all Covered Services, or to be a Network Provider for only some of the Claims Administrator's products. In this case, the Provider will be a Network Provider for the services and products included in the participation agreement, and a Non-Network Provider for other services and products. The participation status of Providers will change from time to time.

NETWORK PROVIDER
The term Network Provider means a Hospital or Professional Provider that has entered into an agreement with the Claims Administrator to provide services at a predetermined cost under the agreement to participate in the EPO option of the Plan or a facility that has been designated by the Claims Administrator as a Network Provider. A Provider may enter into an agreement to provide only certain Covered Services, but not all Covered Services, or to be a Network Provider for only some of the services and products administered by the Claims Administrator. In such case, the Provider will be a Network Provider for the services and products included in the participation agreement, and a Non-Network Provider for other services and products. The participation status of providers may change from time to time.

The Providers qualifying as Network Providers may change from time to time. A list of the current Network Providers may be provided by the Claims Administrator.

NON-NETWORK PROVIDER
The term Non-Network Provider means a Provider other than a Network Provider.

NON-PARTICIPATING PHARMACY
The term Non-Participating Pharmacy means a pharmacy other than a Participating Pharmacy.

NURSE
The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation R.N., L.P.N. or L.V.N.

OCCUPATIONAL THERAPIST
The term Occupational Therapist means a duly licensed Occupational Therapist.

OCCUPATIONAL THERAPY
The term Occupational Therapy means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

OPEN ENROLLMENT PERIOD
The term Open Enrollment Period means a period of time during which Eligible Persons may enroll themselves and Dependents under the Plan. The Plan Administrator will determine the period of time that is the Open Enrollment Period.

OTHER HEALTH CARE FACILITY
The term Other Health Care Facility means a facility other than a Hospital or a Hospice Facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and sub-acute facilities.

OTHER HEALTH CARE PROFESSIONAL
The term Other Health Care Professional means an individual, other than a Physician, who is licensed or otherwise authorized under the applicable state law to deliver medical Services and supplies. Other Health Care Professionals include, but are not limited to, physical therapists, registered Nurses and licensed practical Nurses.

OUT-OF-POCKET
The term Out-of-Pocket applies to expenses that call for Participants to spend cash (i.e., their own money), such as the Participant's share of Co-insurance, Co-payment or Deductible.

OUT-OF-POCKET MAXIMUM
The term Out-of-Pocket Maximum means the maximum amount of Charges for Covered Services you must pay during a Plan Year, including the Deductible, before the Co-insurance percentage of the Plan increases. The individual Out-of-Pocket Maximum applies separately to each Covered Person. When a Covered Person reaches the annual Out-of-Pocket Maximum, the Plan will pay 100% of additional Charges for Covered Services for that individual during the remainder of that Plan Year. The family Out-of-Pocket Maximum applies collectively to all Covered Persons in the same family. When the annual family Out-of-Pocket Maximum is reached, the Plan will pay 100% of Charges for Covered Services for any covered family member during the remainder of that Plan Year. However, expenses for services that do not apply to the Out-of-Pocket Maximum will never be paid at 100%.

The following costs will never apply to the Out-of-Pocket Maximum:
- Any Charges for non-Covered Services.
- Co-payments for Covered Services available by an optional Amendment.
- Charges in excess of the Maximum Allowance
- Co-payments for Services available from HealthFlex vendors or administrators other than Medco and UnitedHealthcare.

In accordance with federal mental health parity regulations, eligible out-of-pocket expenses for both the behavioral health and medical plans count toward one, *shared* Out-of-Pocket Maximum that is determined by the medical Benefit Option in which you are enrolled (the one described in this Benefit Booklet). The annual Out-of-Pocket Maximum amounts are shown on The Schedule of Medical Benefits.

OUTPATIENT
The term Outpatient means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

PARTICIPANT
The term Participant means either the Primary Participant or an Enrolled Dependent, but this term applies only while such person is enrolled under the Plan. References to "you" and "your" throughout this Benefit Booklet are references to a Participant (also called a Covered Person).

PARTICIPATING PHARMACY
The term Participating Pharmacy means the Medco Pharmacy and Retail Pharmacies with which Medco has contracted, either directly or indirectly, to provide Prescription Drug Services. To find a Participating Pharmacy visit **www.medco.com** or access the Medco Web page through the HealthFlex/WebMD website (**www.gbophb.org**).

PHARMACY & THERAPIES (P&T) COMMITTEE
A committee of Provider Organization members comprised of Medical Providers, Pharmacists, Medical Directors and Pharmacy Directors, which reviews medications for safety, efficacy, cost effectiveness and value. The P&T Committee evaluates medications for addition to or deletion from the Formulary and may also set dispensing limits on medications.

PHYSICIAN
The term Physician means a licensed medical practitioner who is practicing within the scope of the license and who is licensed to prescribe and administer drugs and/or to perform Surgery.

PLAN
The term Plan means the group health plan component of the Hospitalization and Medical Expense Program ("HealthFlex") maintained by the General Board on behalf of its Employees and the Employees and other Participants of the organizations and corporations affiliated with the General Board. The Plan is a Church Plan.

PLAN ADMINISTRATOR
The Plan Administrator of the Plan is the General Board of Pension and Health Benefits of The United Methodist Church, Incorporated in Illinois, or its designee.

PRE-EXISTING CONDITION
The term Pre-existing Condition means an Injury or Sickness that is identified by the Plan Administrator as having been diagnosed or treated, or for which prescription medications or drugs were prescribed or taken within the 3-month period immediately preceding the individual's enrollment date. (The enrollment date is the date the individual became covered under the Plan or, if earlier, the first day of any waiting period under the Plan.) A Pre-existing Condition does not include Pregnancy. Genetic information is not an indicator of a Pre-existing Condition, if there is not a diagnosis of a condition related to the genetic information.

PRESCRIPTION DRUG
Prescription Drug means: (a) a drug which has been approved by the U.S. Food and Drug Administration for safety and efficacy; or (b) certain drugs approved under the Drug Efficacy Study Implementation review; or (c) drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a prescription order; or (d) injectable insulin.

PREVENTIVE TREATMENT
The term Preventive Treatment means treatment rendered to prevent disease or its recurrence.

PRIMARY PARTICIPANT
The term Primary Participant means a full-time employee of the General Board, a full-time employee of an Affiliated Organization and any other person eligible under the terms of the Plan

who is currently in Active Service and enrolled in the Plan (including retired Employees age 65 and over who are considered working-aged Employees under the MSP Rules and who do not work for an employer that has elected the Small Employer Exception under the MSP Rules). The term also includes retired employees of the General Board and Affiliated Organizations who are under the age of 65.

PRIVATE DUTY NURSING
The term Private Duty Nursing means Skilled Nursing services provided by an actively practicing licensed Nurse on a one-to-one basis. Private Duty Nursing is shift nursing of 8 hours or greater per day and does not include nursing of less than 8 hours per day. It does not include Custodial Care Service.

PLAN SPONSOR
The term Plan Sponsor means the Conference if the Primary Participant is an employee of a local church or a clergy member; or the Affiliated Organization for other Primary Participants.

PROVIDER
The term Provider means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) or entity duly licensed to render Covered Services to you. Also see the definitions of Network Provider and Non-Network Provider.

PROFESSIONAL PROVIDER
The term Professional Provider means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist or any Provider designated by the Claims Administrator.

RETAIL PHARMACY
The term Retail Pharmacy means a pharmacy that is not the Medco Pharmacy (i.e., not Medco's mail-order pharmacy).

RETAIL REFILL ALLOWANCE (RRA) PROGRAM
The term Retail Refill Allowance Program is a requirement under the Plan pursuant to which Participants will only be allowed to obtain three fills (the initial fill, plus two refills) of maintenance (long-term) drugs at a Participating Retail Pharmacy. For all subsequent fills of the same drug at a Retail Pharmacy, Participants will be responsible for paying 100% of the discounted cost of the drug.

REVIEW ORGANIZATION
The term Review Organization refers to an affiliate of the Claims Administrator or another entity to which the Claims Administrator has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review Services.

SICKNESS
For the purposes of the Plan, the term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of

Sickness. Expenses related to Sickness due to mental illness are covered under the mental and behavioral health portion of the Plan administered by UBH.

SKILLED NURSING
The term Skilled Nursing means services provided by a Nurse that require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. It does not include Custodial Care Service.

SKILLED NURSING FACILITY
The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) that specializes in:

- Physical rehabilitation on an Inpatient basis.
- Skilled nursing and medical care on an inpatient basis, but only if that institution:
  - maintains on the premises all facilities necessary for medical treatment;
  - provides such treatment, for compensation, under the supervision of Physicians; and
  - provides Nurses' Services.

SPINAL TREATMENT
Spinal Treatment means 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.

SPECIALIST
The term Specialist means a Physician who provides specialized services, and is not engaged in general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics.

SPOUSE
The term Spouse, for purposes of the Plan, means a person who is in a marital relationship with a Participant (or with a surviving Spouse) that exists in accordance with the law of the jurisdiction in which the Spouse resides, except that a person who is a "common-law" Spouse shall not be a Spouse for purposes of the Plan. A person who is a Spouse shall still be a Spouse even if the person is geographically or legally separated (but not yet divorced) from the person to whom he or she is married.

SURGERY
The term Surgery means the performance of any medically recognized, non-investigational surgical procedure including the use of specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Claims Administrator.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS
The term Temporomandibular Joint Dysfunction and Related Disorders means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

TERMINAL ILLNESS
A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of 6 months or less to live, as diagnosed by a Physician.

TIER 1 DRUG
The term Tier 1 Drug means, generally, Generic Drugs.

TIER 2 DRUG
The term Tier 2 Drug means, generally, Preferred Brand Name Drugs that are on Medco's Formulary list.

TIER 3 DRUG
The term Tier 3 Drug means, generally, Non-Preferred Brand Name Drugs that are not on Medco's Formulary list, and non-sedating antihistamines and lifestyle drugs like Viagra.

TIER 4 DRUG
The term Tier 4 Drug means, generally, all pre-packaged medications that are on the Formulary list (i.e. Seasonale, which is only packaged in 91-day quantities).

TIER 5 DRUG
The term Tier 5 Drug means, generally, all pre-packaged medications that are not on the Formulary list (i.e. all pre-packaged medications other than Seasonale).

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

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

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

If you have a life-threatening Sickness or condition (one that is likely to cause death within 1 year of the request for treatment) the General Board and the Claims Administrator may, in their discretion, determine that an Unproven Service meets the definition of a Covered Service for that Sickness or condition. For this to take place, the General Board 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
Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by the Claims Administrator, in accordance

with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Therefore, Urgent Care does not normally include dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the Participant should not travel due to any medical condition.

URGENT CARE CENTER
An Urgent Care Center is a facility, other than a Hospital, that provides Covered 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.

General Information

FIDUCIARY AND ADMINISTRATIVE DUTIES

As the Plan Administrator, the General Board has an obligation to follow the terms of the Plan document. The Plan document names the General Board as both the administrator and fiduciary of the Plan. An administrator must perform its duties in a manner consistent with the terms of the Plan. A fiduciary must maintain and administer the Plan in the interest of the Plan and its participants. The fiduciary must perform its duties in a reasonable and prudent manner.

The Plan document grants the General Board the power to delegate fiduciary and non-fiduciary duties and obligations to agents and others.

DUTIES ASSIGNED TO THE PLAN'S CLAIMS ADMINISTRATORS

Under the terms of the administrative services agreements with the Claims Administrators, the General Board has delegated the administrative duties to UHC and Medco to process claims and distribute benefits for the medical and Prescription Drug coverage under the Plan. The General Board, as the Plan Administrator, pays for those benefits through banking arrangements with the Claims Administrators. The General Board has also contractually delegated certain fiduciary duties to the Claims Administrators. Specifically, the General Board has delegated the fiduciary duties with respect to administering claims and hearing appeals of claim denials to UHC and Medco. UHC and Medco, as contracted fiduciaries, have the duty to administer benefits in accordance with the terms of the Plan and in the exclusive interest of the Plan and all of its participants. The General Board, despite the fact that it is still responsible for paying the benefits from Plan assets, does not have the authority, generally, to alter the decisions regarding the duties, i.e., claims and appeals processing, that have been assigned to the Claims Administrators.

FOR MORE INFORMATION

Here are some additional resources, should you have any questions after reviewing all of the information in this Benefit Booklet.

For more information about:

- **The HealthFlex Plan**
  General Board of Pension and Health Benefits of The United Methodist Church
  1901 Chestnut Ave.
  Glenview IL 60025
  www.gbophb.org
  1-800- 851-2201

- **UnitedHealthcare Insurance Company**
  450 Columbus Boulevard
  Hartford, CT 06115-0450
  www.myuhc.com
  1-800-901-1939

- **Medco**
  100 Parsons Pond Drive
  Franklin Lakes, NJ 07417
  www.medco.com
  1-800- 841-2806

The plans described in this document (collectively, the Plans) are maintained and administered by the General Board of Pension and Health Benefits of The United Methodist Church, Incorporated in Illinois (General Board). The Plans are self-funded (or self-insured).

This document contains only a partial, general description of the Plans. It is provided for informational purposes only and should **not** be viewed as a contract, an offer of coverage, or investment, tax, medical, or other advice. In the event of any conflict between this Benefit Booklet and the official plan documents (schedule of benefits, benefit grids, benefit summaries, summary plan description, or plan document), the official plan documents will govern.

The General Board and its affiliates retain the right to amend, terminate or modify the terms of the Plans, as well as any post-retirement health subsidy, at any time, without notice and for any reason.

The Plans are Church Plans within the meaning of section 3(33) of the Employee Retirement Income Security Act and section 414(e) of the Internal Revenue Code. Not all Plans are available in all areas of the United States. The Plans do not cover all health care expenses, and Participants should read the official plan documents carefully to determine which benefits are covered, as well as any applicable exclusions, limitations, and procedures.

All benefits under the Plans are subject to applicable laws, regulations, and policies. All benefits are subject to coordination of benefits provisions. The Plans are subrogated to all of the rights of a plan Participant against any party liable for such Participant's Sickness or Injury, to the extent of the reasonable value of the benefits provided to such Participant under the Plans. The Plans may assert this right independently of a plan Participant, and such Participant is obligated to cooperate with the General Board in order to protect the Plans' subrogation rights.

The General Board does not provide any health care Services and therefore cannot guarantee any results or outcomes. Health care Providers and vendors are independent contractors in private practice and are neither employees nor agents of the General Board. The availability of any particular Provider cannot be guaranteed, and Provider network composition is subject to change.

If you are a plan Participant, call the number on your ID Card for more information about the Plan in which you are enrolled.

Services are provided by UnitedHealthcare Insurance Company and Medco. UnitedHealthcare Insurance Company and Medco provide administrative claims payment Services only and do not assume any financial risk or obligation with respect to Claims.

Exclusive Provider Medical Benefits—The Schedules

THE SCHEDULE — EPO D

For You and Your Dependents
To receive Network Medical Benefits, you and your Dependents may be required to pay a portion of the expenses for Covered Services and supplies. That portion is the Co-payment.

If you are unable to locate a Network Provider in your area who can provide you with a service or supply that is a Covered Service under this Plan, you must call the Plan Administrator to obtain authorization for Non-Network Provider coverage. If you obtain authorization for services provided by a Non-Network Provider, those services will be covered at the Network benefit level described below. You or your Dependent can obtain the names of Network Providers in your area by visiting the website **www.gbophb.org**, logging into HealthFlex/WebMD and accessing the UnitedHealthcare Web page under "HealthFlex Vendor Links," or by calling the toll-free number shown on the back of your ID Card.

Co-Payments/Deductible
Under this plan there is a $500 deductible per participant and a $1,000 family deductible. However, the deductible may be higher if the participant did not meet the Health Quotient (HQ) requirement:

If satisfied HQ requirement
• $500 per person
• $1,000 per family

If did not satisfy HQ requirement
• $750 per person
• $1,250 per family (Participant and children only in Plan)
• $1,500 per family (Participant and spouse in Plan, or Participant and spouse plus children in Plan)

Co-payments are expenses to be paid by you or your Dependent for Covered Services received. Deductible amounts are separate from and not reduced by Co-payments. **Before most of the benefits listed below can be paid, a participant's/dependent's individual deductible must be satisfied in full or the family deductible must be satisfied in full (with the exception of preventive care, which is not subject to this deductible).** Any charges applied toward the deductible would be the participant's responsibility.

Plan Pays:

Plan Maximum Benefits	Network Provider	Non-Network Provider
Lifetime maximum	None	None

How this Plan Works:

	Covered Services from Network Providers
Benefits for care other than for Mental Health and Substance Abuse	You and your Dependent pay any Co-payment shown below, then the Plan pays the Benefit Percentage shown
Physician Services • Primary Care Physician Office Visit • Specialist Physician Office Visit • Surgery performed in the Physician's office • Allergy Treatment/Injections • Allergy Serum (dispensed by the Physician in the office)	 • Plan pays 100% after a $30 Co-payment • Plan pays 100% after a $50 Co-payment • Plan pays 100% after a Primary Care Physician ($30) or a Specialist Office Visit ($50) Co-payment • Plan pays 100% • Plan pays 100%
Well Child Care <u>(under age 16)</u> • Includes charges for office visits, age-appropriate immunizations and routine diagnostic tests. There is a one visit per year maximum for children age 2 and older.	• Plan pays 100% *Plan pays 100% for X-ray/lab services billed by a separate Outpatient diagnostic facility as long as these services were rendered in the office of a network provider*
Well Adult Care (age 16 & over) • One well person exam annually, including charges for an office visit, routine mammogram, pap smear, prostate exam, routine blood work and colorectal screening for cancer. • Colonoscopy (covered once every three years for Participants age 45 and older)	• Plan pays 100% *Plan pays 100% for X-ray/lab services billed by a separate Outpatient diagnostic facility as long as these services were rendered in the office of a network provider* • Plan pays 100%

How this Plan Works:

	Covered Services from Network Providers
Lab and X-ray • • • •	Add Benefit •
Inpatient Hospital Facility Services • Semi Private Room and Board • Private Room and Board • Special Care Units (ICU/CCU) and Board	Plan pays 100% after a $750Co-Payment* per admission • Limited to the Hospital's negotiated rate with the Claims Administrator • Limited to the Hospital's negotiated rate, with the Claims Administrator, for a semi-private room • Limited to the Hospital's negotiated rate with the Claims Administrator **If you are readmitted to the hospital within 30 days for the same condition, the $500 Co-Payment will be waived.*
Outpatient Hospital Facility Services Operating Room, Recovery Room, Procedure Room and Treatment	Plan pays 100% after a $500 Co-Payment per admission
Inpatient Hospital Doctor's Visits/ Consultations	Plan pays 100%
Inpatient Hospital Professional Services: Surgeon, Radiologist, Pathologist and Anesthesiologist	Plan pays 100%
Outpatient Professional Services: Surgeon, Radiologist, Pathologist and Anesthesiologist	Plan pays 100%
Second Opinions: Services will be provided on a voluntary basis • Primary Care Physician Office Visit • Specialist Physician Office Visit	 • Plan pays 100% after a $30 Co-payment per visit • Plan pays 100% after a $50 Co-payment per visit

How this Plan Works:

	Covered Services from Network Providers
Emergency and Urgent Care Services • Primary Care Physician Office Visit • Specialist Physician Office Visit • Hospital Emergency Room • Urgent Care Facility or Outpatient Facility • Ambulance	• Plan pays 100% after $30 Co-payment per visit • Plan pays 100% after $50 Co-payment per visit • Plan pays 100% after $200 Co-Payment* per visit** • Plan pays 100% after $100 Co-Payment* per visit • Plan pays 100%** ** Waived if Admitted* *** Not covered unless a true emergency as defined in the Plan*
Inpatient Services at Other Health Care Facilities Includes: Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: 120 days	Plan pays 100%
Major X-Ray , Laboratory and Radiology Service • MRIs, MRAs, CAT Scans and PET Scans •	• Plan pays 100% •
Home Health Care Calendar Year Maximum: 60 visits	Plan pays 100%
Private Duty Nursing Annual Maximum: $24,000	Plan pays 100%
Hospice • Inpatient Facility • Outpatient Services • Hospice Room and Board Calendar Year Maximum: None	• Plan pays 100% • Plan pays 100% • Limited to the Hospice Facility's negotiated rate with the Claims Administrator
Bereavement Counseling • Inpatient Facility • Outpatient Services *Limited to 3 counseling sessions within 1 year of decedent's death*	• Plan pays 100% for services provided as part of the Hospice Care Program • Plan pays 100% for services provided as part of the Hospice Care Program

How this Plan Works:

	Covered Services from Network Providers
Outpatient Short-Term Rehabilitative Therapy:	
• Physical Therapy	• Plan pays 100% after a $30 Co-payment per visit
• Occupational Therapy Combined annual maximum: $6,000	• Plan pays 100% after a $30 Co-payment per visit
• Speech Therapy Annual Maximum: $4,000 *In addition, there is a 20-visit calendar year maximum for speech therapy for pervasive development disorders in relation to serious mental illness (SMI)*	• Plan pays 100% after a $30 Co-payment per visit
Alternative Therapy	
• Chiropractic care	• Plan pays 100% after a $30 Co-payment per visit
• Massage therapy	• Plan pays 100% after a $50 Co-payment per visit
• Naprapathy	• Plan pays 100% after a $50 Co-payment per visit
• Acupuncture Combined annual maximum: $1,000	• Plan pays 100% after a $50 Co-payment per visit
Maternity	
• Initial Visit to Confirm Pregnancy	• Plan pays 100% after a $30 Co-payment
• All Subsequent Physician's charges for Prenatal Visits, Postnatal Visits, and Delivery	• Plan pays 100%
• Facility Charges (Inpatient Hospital, Birthing Center)	• Same as the Plan's Inpatient Hospital Facility Benefit
Abortion (Non-elective procedures only)	
• Inpatient Facility	• Same as the Plan's Inpatient Hospital Facility Benefit
• Outpatient Facility	• Same as the Plan's Outpatient Hospital Facility Benefit
• Physician's Services	• Plan pays 100%

How this Plan Works:

	Covered Services from Network Providers
Family Planning Office visits including tests and counseling • Primary care physician • Specialist	 • Plan pays 100% after a $30 Co-payment per visit • Plan pays 100% after a $50 Co-payment per visit
Surgical Sterilization Procedures for Vasectomy/ Tubal Ligations (excluding reversals) • Inpatient Facility • Outpatient Facility • Physician's Services	 • Same as the Plan's Inpatient Hospital Facility Benefit • Same as the Plan's Outpatient Hospital Facility Benefit • Plan pays 100%
Infertility Treatment Office Visit (Tests, Counseling) Surgical Treatment: Includes procedures for Correction of Infertility, In Vitro Fertilization, Artificial Insemination, GIFT, ZIFT • Inpatient Facility • Outpatient Facility • Physician's Services	 Plan pays 100% after Plan's Primary Care Physician ($30) or Specialist Office Visit ($50) Co-payment • Same as the Plan's Inpatient Hospital Facility Benefit • Same as the Plan's Outpatient Hospital Facility Benefit • Plan pays 100%
Organ transplants (Includes all medically appropriate non-experimental transplants) • United Healthcare Resource Network (URN) Center facility • United Healthcare Resource Network (URN) Center Physician • Travel services maximum *Covered only when transplant procedure is performed at a United Healthcare Resource Network (URN) Center facility.*	Same as the Plan's Inpatient Hospital Facility benefit • Same as the Plan's Inpatient Hospital Facility benefit • Plan pays 100% • $10,000 per transplant; any daily limitations are subject to IRS regulations

How this Plan Works:

	Covered Services from Network Providers
Durable Medical Equipment Calendar Year Maximum: $10,000 (excluding life-sustaining equipment)	Plan pays 100%
External Prosthetic Appliances Calendar Year Maximum: $10,000 *This benefit includes coverage for cranial prosthetics, with a separate lifetime maximum of $1,000 for wigs if you have received radiation therapy and/or chemotherapy*	Plan pays 100%
Hearing Benefits • Hearing exam and evaluations • Hearing aid (excludes replacement and repair)	 • Plan pays 100% after a $50 Co-payment per visit • Plan pays 50% up to $500 per ear every 24 months, (no deductible)
Dental Care (Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth) • Physician's office • Inpatient Facility • Outpatient Facility • Physician's Services	 • Plan pays 100% after a $50 Co-payment per visit • Same as the Plan's Inpatient Hospital Facility Benefit • Same as the Plan's Outpatient Hospital Facility Benefit • Plan pays 100%
Temporomandibular Joint Disorder (Surgical & Non-Surgical Treatment) • Office Visit • Inpatient Facility • Outpatient Facility • Physician's Services	 • Plan pays 100% after a $50 Co-payment per visit • Same as the Plan's Inpatient Hospital Facility Benefit • Same as the Plan's Outpatient Hospital Facility Benefit • Plan pays 100%
<u>Licensed Dietitian</u> • Office Visit	 Plan pays 100% after a $30 Co-payment

Preferred Provider Medical Benefits – The Schedules

THE SCHEDULE — PPO OPTION B500

For You and Your Dependents
This Plan provides medical benefits for services and supplies provided by Network Providers and Non-Network Providers, unless otherwise noted. You will be required to pay a portion of the Charges for most Covered Services, whether or not those services were rendered by Network or Non-Network Providers. That portion is the Co-payment, Deductible or Co-insurance. You or your Dependent can obtain the names of Network Providers in your area by visiting the website **www.gbophb.org**, logging into HealthFlex/WebMD and accessing the UnitedHealthcare Web page under "HealthFlex Vendor Links," or by calling the toll-free number shown on the back of your ID Card.

Co-Insurance
The term Co-insurance means the percentage of Charges for Covered Services that a Participant is required to pay under the Plan.

Co-Payments/Deductibles
Co-payments are expenses to be paid by you or your Dependent for covered Services received. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Co-payments. Co-payments and Deductibles must be paid in addition to any Co-insurance.

Plan Pays:

Plan Maximum Benefits	Network Provider	Non-Network Provider
Lifetime Maximum	None	None

You Pay:

Deductibles	Network Provider	Non-Network Provider
Individual Deductible	*If satisfied HealthQuotient (HQ) requirement* • $500 per person *If did not satisfy HQ requirement* • $750 per person	*If satisfied HQ requirement* • $1,000 per person *If did not satisfy HQ requirement* • $1,250 per person
Family Deductible	*If satisfied HQ requirement* • $1,000 per family *If did not satisfy HQ requirement* • $1,250 per family (children only) • $1,500 per family (spouse, or spouse and children) After Network Provider Deductibles totaling $1,000 (or higher) have been applied in a Calendar Year for either: • you and your Dependents, or • your Dependents, your family does not need to satisfy any further medical Deductibles for the rest of that year.	*If satisfied HQ requirement* • $2,000 per family *If did not satisfy HQ requirement* • $2,250 per family (children only) • $2,500 per family (spouse, or spouse and children) After Non-Network Provider Deductibles totaling $2,000 (or higher) have been applied in a Calendar Year for either: • you and your Dependents, or • your Dependents, your family does not need to satisfy any further medical Deductible for the rest of that year.
Out-of-Pocket Maximums • Individual Out-of-Pocket Maximum	$3,000 per person	$6,000 per person
• Family Out-of-Pocket Maximum	$6,000 per family After Network Provider Out-of-Pocket Expenses totaling $6,000 have been incurred in a Calendar Year for either: • you and your Dependents, or • your Dependents, your family does not need to satisfy any further Out-of-Pocket Expenses for the rest of that year.	$12,000 per family After Non-Network Provider Out-of-Pocket Expenses totaling $12,000 have been incurred in a Calendar Year for either: • you and your Dependents, or • your Dependents, your family does not need to satisfy any further Out-of-Pocket Expenses for the rest of that year.

Out-of-Pocket Ex penses
Out-of-pocket expenses are expenses for Covered Services from Network Providers and Non-Network Providers for which no payment is provided because of the Co-payments, Deductible and Coinsurance. However, Charges for Covered Services incurred for or in connection with Non-Network Providers in excess of the Reasonable charges or Inpatient Hospital deductibles will not accumulate toward the Out-of-Pocket Maximums.

Simultaneous Accumulation of Deductibles and Out-of-Pocket Maximums
Charges incurred for Covered Services from either Network or Non-Network Providers will be used to satisfy both the Network Provider Deductible and Out-of-Pocket Maximum and the Non-Network Provider Deductible and Out-of-Pocket Maximum simultaneously, until the Network Provider Deductible and Out-of-Pocket Maximum have been satisfied. However, only Charges made by Non-Network Providers will be used to satisfy the remainder of the Non-Network Provider Deductible and Out-of-Pocket Maximum.

Co-Payments, amounts applied toward your Deductible, and any Co-insurance from eligible charges will be used to satisfy your Out-of-Pocket Maximum. Your Out-of-Pocket Maximum can be satisfied by eligible charges from the medical plan as well as the behavioral health plan. Any charges in excess of the Maximum Allowance and any hospital admission co-payments for Non-Participating Providers cannot be used to satisfy your Out-of-Pocket Maximum.

How This Plan Works:

	Network Provider	Non-Network Provider
Benefits for care other than for mental health and substance abuse	You and your Dependent are responsible for the Network Provider Co-payments, the Network Provider Deductible shown below plus the Co-insurance, then the Plan pays the benefit percentage shown.	You and your Dependent are responsible for the Non-Network Provider Deductible shown below plus the Co-insurance, then the Plan pays the benefit percentage shown.

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Physician Services • Primary Care Physician office visit • Specialist Physician office visit • Surgery performed in the Physician's office • Allergy Treatment/Injections • Allergy serum (dispensed by the Physician in the office)	• Plan pays 100% after a $30 Co-payment per visit • Plan pays 100% after a $50 Co-payment per visit • Plan pays 80% after the Deductible • Plan pays 100% • Plan pays 100%	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible
Well child care (under age 16) • Includes charges for office visits, age-appropriate immunizations and routine diagnostic tests. There is a one visit per year maximum for children age 2 and older.	Plan pays 100% *Plan pays 100% for X-ray/lab services billed by a separate Outpatient diagnostic facility as long as these services were rendered in the office of a network provider*	Plan pays 100% up to $100 calendar year maximum for all services (office visits, exams, and tests)
• Primary Care Physician office visit • Specialist Physician office visit • Outpatient facility • Independent lab and X-ray facility	• Plan pays 100% after a $30 Co-payment • Plan pays 100% after a $50 Co-payment • Plan pays 80% after the Deductible • Plan pays 100%	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Inpatient Hospital facility services • Semi-private room and board • Private room and board • Special care units (ICU/CCU room and board)	Plan pays 80% after the Deductible • Limited to the Hospital's negotiated rate for a semi-private room • Limited to the Hospital's negotiated rate for a semi-private room • Limited to the Hospital's negotiated rate	$200 Co-payment per admission, then the Plan pays 60% after the Plan deductible • Limited to the Hospital's most common daily rate for a semi-private room • Limited to the Hospital's most common daily rate for a semi-private room • Limited to the Hospital's most common daily rate for an ICU/CCU room
Outpatient Hospital facility services Operating Room, Recovery room, Procedure Room and Treatment	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Inpatient Hospital Doctor's Visits/Consultations	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Inpatient Hospital Professional Services (e.g., Surgeon, Radiologist, Pathologist, Anesthesiologist)	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Outpatient Professional Services (e.g., Surgeon, Radiologist, Pathologist, Anesthesiologist)	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Second Opinions Services will be provided on a voluntary basis • Primary Care Physician office visit • Specialist Physician office visit	 • Plan pays 100% after a $30 Co-payment • Plan pays 100% after a $50 Co-payment	 • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Emergency and urgent care services • Primary Care Physician office visit	• Plan pays 100% after a $30 Co-payment per visit	• Plan pays 100% after a $30 Co-payment per visit**
• Specialist office visit	• Plan pays 100% after a $50 Co-payment per visit	• Plan pays 100% after a $50 Co-payment per visit**
• Hospital Emergency Room	• Plan pays 100% after a $200 Co-payment* per visit**	• Plan pays 100% after a $200 Co-payment* per visit**
• Urgent Care Facility or Outpatient Facility	• Plan pays 100% after a $100 Co-payment* per visit	• Plan pays 100% after a $100 Co-payment* per visit
• Ambulance	• 80% after Deductible	• 80% after Deductible
In order to be covered, these services must be rendered as a result of a true emergency as defined in the Plan	** Waived if admitted* ***If not a true emergency as defined in the Plan, the Plan pays 80% after the Deductible.*	** Waived if admitted* *** If not a true emergency as defined in the Plan, the Plan pays 60% after the Deductible*
Inpatient Services at Other Health Care Facilities (e.g., Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute facilities) Calendar Year Maximum: 120 days	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Major X-Ray , Laboratory and Radiology Service • MRIs, MRAs, CAT Scans and PET Scans	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Home Health Care Calendar Year Maximum: 60 visits	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Private Duty Nursing Annual Maximum: $24,000	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Hospice • Inpatient Facility • Outpatient Facility • Hospice Room and Board Calendar Year Maximum: None	• Plan pays 80% after the Deductible • Plan pays 80% after the Deductible • Limited to the hospice facility's negotiated rate with the Claims Administrator	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Limited to the hospice facility's most common daily rate for a semi-private room
Bereavement Counseling • Inpatient Facility • Outpatient Services *Limited to three counseling sessions within one year of decedent's death*	• Plan pays 80% after the Deductible for Services provided as part of the Hospice Care Program • Plan pays 80% after the Deductible for Services provided as part of the Hospice Care Program	• Plan pays 60% after the Deductible for Services provided as part of the Hospice Care Program • Plan pays 60% after the Deductible for Services provided as part of the Hospice Care Program

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Outpatient Short-Term Rehabilitative Therapy Includes: • Physical therapy • Occupational therapy Combined annual maximum: $6,000 • Speech therapy Annual maximum: $4,000 *In addition, there is a 20-visit calendar year maximum for speech therapy for pervasive development disorders in relation to serious mental illness (SMI)*	• Plan pays 100% after a $30 Co-payment • Plan pays 100% after a $30 Co-payment • Plan pays 100% after a $30 Co-payment	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible
Alternative therapy Includes: • Chiropractic care • Massage therapy • Acupuncture • Naprapathy *Combined annual maximum: $1,000*	• Plan pays 100% after a $30 Co-payment • Plan pays 50%, no Deductible • Plan pays 50%, no Deductible • Plan pays 50%, no Deductible	• Plan pays 50% after the Deductible • Plan pays 50%, no Deductible • Plan pays 50%, no Deductible • Plan pays 50%, no Deductible
Maternity • Initial visit to confirm pregnancy • All subsequent Physician's Charges for prenatal visits, postnatal visits and delivery • Facility Charges (Inpatient Hospital, birthing center)	• Plan pays 100% after a $30 Co-payment • Plan pays 80% after the Deductible • Same as Plan's Inpatient Hospital facility benefit (No Deductible for newborn)	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Same as Plan's Inpatient Hospital facility benefit

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Abortion (Non-elective procedures only)		
• Inpatient Facility	• Same as Plan's Inpatient Hospital facility benefit	• Same as Plan's Inpatient Hospital facility benefit
• Outpatient Facility	• Same as Plan's Outpatient Hospital facility benefit	• Same as Plan's Outpatient Hospital facility benefit
• Physician's Services	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
Family Planning Office visits including tests and counseling		
• Primary Care Physician	• Plan pays 100% after a $30 Co-payment per visit	• Plan pays 60% after the Deductible
• Specialist Physician	• Plan pays 100% after a $50 Co-payment per visit	• Plan pays 60% after the Deductible
Surgical Sterilization Procedures for Vasectomy/ Tubal Ligation (excluding reversals)		
• Inpatient facility	• Same as Plan's Inpatient Hospital facility benefit	• Same as Plan's Inpatient Hospital facility benefit
• Outpatient facility	• Same as Plan's Outpatient Hospital facility benefit	• Same as Plan's Outpatient Hospital facility benefit
• Physician's services	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Infertility Treatment Office Visit (includes tests and counseling)		
• Primary Care Physician	• Plan pays 100% after a $30 Co-payment per visit	• Plan pays 60% after the Deductible
• Specialist Physician	• Plan pays 100% after a $50 Co-payment per visit	• Plan pays 60% after the Deductible
Surgical treatment (i.e., procedures for correction of infertility, In Vitro Fertilization, Artificial Insemination, GIFT and ZIFT)		
• Inpatient Facility	• Same as Plan's Inpatient Hospital facility benefit	• Same as Plan's Inpatient Hospital facility benefit
• Outpatient Facility	• Same as Plan's Outpatient Hospital facility benefit	• Same as Plan's Outpatient Hospital facility benefit
• Physician's Services	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
Organ transplants (Includes all medically appropriate non-experimental transplants)		
• UnitedHealthcare United Resource Network (URN) Center facility	• Plan pays 80% after the Deductible	• Not covered
• UnitedHealthcare United Resource Network (URN) Center Physician	• Plan pays 80% after the Deductible	• Not covered
• Travel services maximum *Covered only when transplant procedure is performed at a UnitedHealthcare United Resource Network (URN) Center facility*	• $10,000 per transplant; any daily limitation is subject to IRS regulations	• Not covered
Durable Medical Equipment Calendar Year Maximum: $10,000 (excluding life-sustaining equipment)	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
External prosthetic appliances • Calendar Year Maximum: $10,000 *This benefit includes coverage for cranial prosthetics with a separate lifetime maximum of $1,000 for wigs if you have received radiation therapy and/or chemotherapy*	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Hearing Benefits • Hearing exam and evaluation • Hearing aid (excludes replacement and repair)	• Plan pays 100% after a $50 Co- payment • Plan pays 50% up to $500 per ear every 24 months, (no Deductible)	• Plan pays 60% after the Deductible • Plan pays 50% up to $500 per ear every 24 months, (no Deductible)
Dental care (Limited to charges made for a continuous course of dental treatment started within six months of an Injury to sound, natural teeth) • Physician's Office Visit • Inpatient facility • Outpatient facility • Physician services	• Plan pays 100% after a $50 Co-payment • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Dental care (Limited to charges made for a continuous course of dental treatment started within six months of an Injury to sound, natural teeth)		
• Physician's Office Visit	• Plan pays 100% after a $50 Co-payment	• Plan pays 60% after the Deductible
• Inpatient facility	• Same as Plan's Inpatient Hospital facility benefit	• Same as Plan's Inpatient Hospital facility benefit
• Outpatient facility	• Same as Plan's Outpatient Hospital facility benefit	• Same as Plan's Outpatient Hospital facility benefit
• Physician services	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
Temporomandibular Joint Disorder (Surgical and Non-Surgical Treatment)		
• Office Visit	• Plan pays 100% after a $50 Co-payment	• Plan pays 60% after the Deductible
• Inpatient Facility	• Same as Plan's Inpatient Hospital facility benefit	• Same as Plan's Inpatient Hospital facility benefit
• Outpatient Facility	• Same as Plan's Outpatient Hospital facility benefit	• Same as Plan's Outpatient Hospital facility benefit
• Physician services	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
<u>Licensed Dietitian</u>		
• Office Visit	• Plan pays 100% after a $30 Co-payment	• Plan pays 100% after a $30 Co-payment

THE SCHEDULE — PPO OPTION B750

For You and Your Dependents

This Plan provides medical benefits for services and supplies provided by Network Providers and Non-Network Providers, unless otherwise noted. You will be required to pay a portion of the Charges for most Covered Services whether or not those services were rendered by Network or Non-Network Providers. That portion is the Co-payment, Deductible or Co-insurance. You or your Dependent can obtain the names of Network Providers in your area by visiting the website **www.gbophb.org**, logging into HealthFlex/WebMD and accessing the UnitedHealthcare Web page under "HealthFlex Vendor Links," or by calling the toll-free number on the back of your ID Card.

Co-Insurance

The term Co-Insurance means the percentage of Charges for Covered Services that a Participant is required to pay under the Plan.

Co-Payments/Deductibles

Co-payments are expenses to be paid by you or your Dependent for Covered Services received. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Co-payments. Co-payments and Deductibles must be paid in addition to any Co-insurance.

Plan Pays:

Plan Maximum Benefits	Network Provider	Non-Network Provider
Lifetime Maximum	None	None

You Pay:

Deductibles	Network Provider	Non-Network Provider
Individual Deductible	*If satisfied HealthQuotient (HQ) requirement* • $750 per person *If did not satisfy HQ requirement* • $1,000 per person	*If satisfied HQ requirement* • $1,500 per person *If did not satisfy HQ requirement* • $1,750 per person
Family Deductible	*If satisfied HQ requirement* • $1,500 per family *If did not satisfy HQ requirement* • $1,750 per family(children only) • $2,000 per family (spouse or spouse and children) After Network Provider Deductibles totaling $1,500 (or higher) have been applied in a Calendar Year for either: • you and your Dependents, or • your Dependents, your family does not need to satisfy any further medical Deductibles for the rest of that year.	*If satisfied HQ requirement* • $3,000 per family *If did not satisfy HQ requirement* • $3,250 per family (children only) • $3,500 per family (spouse or spouse and children) After Non-Network Provider Deductibles totaling $3,000 (or higher) have been applied in a Calendar Year for either: • you and your Dependents, or • your Dependents, your family does not need to satisfy any further medical Deductible for the rest of that year.
Out-of-Pocket Maximums • Individual Out-of- Pocket Maximum	$3,500 per person	$7,000 per person

You Pay:

Plan Feature	Network Provider	Non-Network Provider
• Family Out-of-Pocket Maximum	$7,000 per family After Network Provider Out-of-Pocket Expenses totaling $7,000 have been incurred in a Calendar Year for either: • you and your Dependents, or • your Dependents, your family does not need to satisfy any further Out-of-Pocket Expenses for the rest of that year.	$14,000 per family After Non-Network Provider Out-of-Pocket Expenses totaling $14,000 have been incurred in a Calendar Year for either: • you and your Dependents, or • your Dependents, your family does not need to satisfy any further Out-of-Pocket Expenses for the rest of that year.

Out-of-Pocket Expenses
Out-of-Pocket Expenses are expenses for Covered Services from Network Providers and Non-Network Providers for which no payment is provided because of the Co-payments, Deductible and Co-insurance. However, Charges for Covered Services incurred for or in connection with Non-Network Providers in excess of the Reasonable charges or Inpatient Hospital deductibles will not accumulate toward the Out-of-Pocket Maximums.

Simultaneous Accumulation of Deductibles and Out-of-Pocket Maximums
Charges incurred for Covered Services from either Network or Non-Network Providers will be used to satisfy both the Network Provider Deductible and Out-of-Pocket Maximum and the Non-Network Provider Deductible and Out-of-Pocket Maximum simultaneously, until the Network Provider Deductible and Out-of-Pocket Maximum have been satisfied. However, only Charges made by Non-Network Providers will be used to satisfy the remainder of the Non-Network Provider Deductible and Out-of-Pocket Maximum.

Co-Payments, amounts applied toward your Deductible, and any Co-Insurance from eligible charges will be used to satisfy your Out-of-Pocket Maximum. Your Out-of-Pocket Maximum can be satisfied by eligible charges from the medical plan as well as the behavioral health plan. Any charges in excess of the Maximum Allowance and any hospital admission co-payments for Non-Participating Providers cannot be used to satisfy your Out-of-Pocket Maximum.

How this Plan Works:

	Network Provider	Non-Network Provider
Benefits for care other than for mental health and substance abuse	You and your Dependent are responsible for the Network Provider Co-payments, the Network Provider Deductible shown below plus the Co-insurance, then the Plan pays the benefit percentage shown.	You and your Dependent are responsible for the Non-Network Provider Deductible shown below plus the Co-insurance, then the Plan pays the benefit percentage shown.

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Physician Services • Primary Care Physician office visit • Specialist Physician office visit • Surgery performed in the Physician's office • Allergy Treatment/Injections • Allergy serum (dispensed by the Physician in the office)	• Plan pays 100% after a $30 Co-payment per visit • Plan pays 100% after a $50 Co-payment per visit • Plan pays 80% after the Deductible • Plan pays 100% • Plan pays 100%	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible
Well child care (under age 16) • Includes charges for office visits, age-appropriate immunizations and routine diagnostic tests. There is a one visit per year maximum for children age 2 and older.	Plan pays 100% *Plan pays 100% for X-ray/lab services billed by a separate Outpatient diagnostic facility as long as these services were rendered in the office of a network provider.*	Plan pays 100% up to $100 calendar year maximum for all services (office visits, exams, and tests)
Pre-Admission Testing • Primary Care Physician office visit • Specialist Physician office visit • Outpatient facility • Independent lab and X-ray facility	• Plan pays 100% after a $30 Co-payment • Plan pays 100% after a $50 Co-payment • Plan pays 80% after the Deductible • Plan pays 100%	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Inpatient Hospital Facility Services	Plan pays 80% after the Deductible	$200 Co-payment per admission, then the Plan pays 60% after the Plan deductible
• Semi-private room and board	• Limited to the Hospital's negotiated rate, with the Claims Administrator for a semi-private room	• Limited to the Hospital's most common daily rate for a semi-private room
• Private room and board	• Limited to the Hospital's negotiated rate with the Claims Administrator for a semi-private room	• Limited to the Hospital's most common daily rate for a semi-private room
• Special care units (ICU/CCU room and board)	• Limited to the Hospital's negotiated rate with the Claims Administrator	• Limited to the Hospital's most common daily rate for an ICU/CCU room
Outpatient Hospital Facility Services Operating Room, Recovery Room, Procedure Room and Treatment	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Inpatient Hospital Doctor's Visits/Consultations	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Inpatient Hospital Professional Services (e.g., Surgeon, Radiologist, Pathologist, Anesthesiologist)	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Outpatient Professional Services (e.g., Surgeon, Radiologist, Pathologist, Anesthesiologist)	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Second Opinions: Services will be provided on a voluntary basis		
• Primary Care Physician Office Visit	• Plan pays 100% after a $30 Co-payment	• Plan pays 60% after the Deductible
• Specialist Physician Office Visit	• Plan pays 100% after a $50 Co-payment	• Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Emergency and Urgent Care Services • Primary Care Physician Office Visit	• Plan pays 100% after a $30 Co-payment per visit	• Plan pays 100% after a $30 Co-payment per visit**
• Specialist Office Visit	• Plan pays 100% after a $50 Co-payment per visit	• Plan pays 100% after a $50 Co-payment per visit**
• Hospital Emergency Room	• Plan pays 100% after a $200 Co-payment* per visit**	• Plan pays 100% after a $200 Co-payment* per visit**
• Urgent Care Facility or Outpatient Facility	• Plan pays 100% after a $100 Co-payment* per visit	• Plan pays 100% after a $100 Co-payment* per visit
• Ambulance	• 80% after Deductible	• 80% after Deductible
In order to be covered, these services must be rendered as a result of a true emergency as defined in the Plan	** Waived if admitted* ***If not a true emergency as defined in the Plan, the Plan pays 80% after the Deductible.*	** Waived if admitted* *** If not a true emergency as defined in the Plan, the Plan pays 60% after the Deductible*
Laboratory and Radiology Services • MRIs, MRAs, CAT Scans and PET Scans • Other Laboratory and Radiology Services *All charges billed by an independent facility*	• Plan pays 80% after the Deductible • Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible
Home Health Care Calendar Year Maximum: 60 visits	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Private Duty Nursing Annual Maximum: $24,000	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Bereavement Counseling • Inpatient Facility	• Plan pays 80% after the Deductible for Services provided as part of the Hospice Care Program	• Plan pays 60% after the Deductible for Services provided as part of the Hospice Care Program
• Outpatient Services *Limited to three counseling sessions within one year of decedent's death*	• Plan pays 80% after the Deductible for Services provided as part of the Hospice Care Program	• Plan pays 60% after the Deductible for Services provided as part of the Hospice Care Program
Outpatient Short-Term Rehabilitative Therapy Includes: • Physical Therapy	• Plan pays 100% after a $30 Co-payment	• Plan pays 60% after the Deductible
• Occupational Therapy Combined Annual Maximum: $6,000	• Plan pays 100% after a $30 Co-payment	• Plan pays 60% after the Deductible
• Speech therapy Annual maximum: $4,000 *In addition, there is a 20-visit calendar year maximum for speech therapy for pervasive development disorders in relation to serious mental illness (SMI).*	• Plan pays 100% after a $30 Co-payment	• Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Alternative Therapy Includes: • Chiropractic care • Massage therapy • Acupuncture • Naprapathy *Combined annual maximum: $1,000*	• Plan pays 100% after a $30 Co-payment • Plan pays 50%, no Deductible • Plan pays 50%, no Deductible • Plan pays 50%, no Deductible	• Plan pays 50% after the Deductible • Plan pays 50%, no Deductible • Plan pays 50%, no Deductible • Plan pays 50%, no Deductible
Maternity • Initial visit to confirm pregnancy • All subsequent Physician's Charges for prenatal visits, postnatal visits and delivery • Facility Charges (Inpatient Hospital, birthing center)	• Plan pays 100% after a $30 Co-payment • Plan pays 80% after the Deductible • Same as Plan's Inpatient Hospital facility benefit (No Deductible for newborn)	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Same as Plan's Inpatient Hospital facility benefit
Abortion (Non-elective procedures only) • Inpatient Facility • Outpatient Facility • Physician's Services	• Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 80% after the Deductible	• Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 60% after the Deductible
Family Planning Office visits including tests and counseling • Primary Care Physician • Specialist physician	• Plan pays 100% after a $30 Co-payment per visit • Plan pays 100% after a $50 Co-payment per visit	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Surgical Sterilization Procedures for Vasectomy/ Tubal Ligation (excluding reversals)		
• Inpatient facility	• Same as Plan's Inpatient Hospital facility benefit	• Same as Plan's Inpatient Hospital facility benefit
• Outpatient facility	• Same as Plan's Outpatient Hospital facility benefit	• Same as Plan's Outpatient Hospital facility benefit
• Physician's services	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
Infertility Treatment Office Visit (includes tests and counseling)		
• Primary Care Physician	• Plan pays 100% after a $30 Co-payment per visit	• Plan pays 60% after the Deductible
• Specialist Physician	• Plan pays 100% after a $50 Co-payment per visit	• Plan pays 60% after the Deductible
Surgical treatment (i.e., procedures for correction of infertility, In Vitro Fertilization, Artificial Insemination, GIFT, ZIFT)		
• Inpatient Facility	• Same as Plan's Inpatient Hospital facility benefit	• Same as Plan's Inpatient Hospital facility benefit
• Outpatient Facility	• Same as Plan's Outpatient Hospital facility benefit	• Same as Plan's Outpatient Hospital facility benefit
• Physician's Services	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Durable Medical Equipment Calendar Year Maximum: $10,000 (excluding life-sustaining equipment)	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
External prosthetic appliances • Calendar Year Maximum: $10,000 *This benefit includes coverage for cranial prosthetics with a separate lifetime maximum of $1,000 for wigs if you have received radiation therapy and/or chemotherapy*	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Hearing Benefits • Hearing exam and evaluation • Hearing aid (excludes replacement and repair)	• Plan pays 100% after a $50 Co- payment • Plan pays 50% up to $500 per ear every 24 months, (no Deductible)	• Plan pays 60% after the Deductible • Plan pays 50% up to $500 per ear every 24 months, (no Deductible)

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Dental care (Limited to charges made for a continuous course of dental treatment started within six months of an Injury to sound, natural teeth) • Physician's Office Visit • Inpatient facility • Outpatient facility • Physician services	• Plan pays 100% after a $50 Co- payment • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient facility benefit • Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 60% after the Deductible
Temporomandibular Joint Disorder (Surgical and Non-Surgical Treatment) • Office Visit • Inpatient Facility • Outpatient Facility • Physician services	• Plan pays 100% after a $50 Co-payment • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 60% after the Deductible
Licensed Dietitian • Office Visit	• Plan pays 100% after a $30 Co-payment	• Plan pays 100% after a $30 Co-payment

THE SCHEDULE — PPO OPTION B1000

For You and Your Dependents

This Plan provides medical benefits for services and supplies provided by Network Providers and Non-Network Providers, unless otherwise noted. You will be required to pay a portion of the Charges for most Covered Services whether or not those services were rendered by Network or Non-Network Providers. That portion is the Co-payment, Deductible or Co-insurance. You or your Dependent can obtain the names of Network Providers in your area by visiting the website **www.gbophb.org**, logging into HealthFlex/WebMD and accessing the UnitedHealthcare Web page under "HealthFlex Vendor Links," or by calling the toll-free number shown on the back of your ID Card.

Co-Insurance

The term Co-insurance means the percentage of Charges for Covered Services that a Participant is required to pay under the Plan.

Co-Payments/Deductibles

Co-payments are expenses to be paid by you or your Dependent for Covered Services received. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Co-payments. Co-payments and Deductibles must be paid in addition to any Co-insurance.

Plan Pays:

Plan Maximum Benefits	Network Provider	Non-Network Provider
Lifetime Maximum	None	None

You Pay:

Deductibles	Network Provider	Non-Network Provider
Individual Deductible	*If satisfied HealthQuotient (HQ) requirement* • $1,000 per person *If did not satisfy HQ requirement* • $1,250 per person	*If satisfied HQ requirement* • $2,000 per person *If did not satisfy HQ requirement* • $2,250 per person
Family Deductible	*If satisfied HQ requirement* • $2,000 per family *If did not satisfy HQ requirement* • $2,250 per family (children only) • $2,500 per family(spouse, or spouse and children) After Network Provider Deductibles totaling $2,000 (or higher) have been applied in a Calendar Year for either: • you and your Dependents, or • your Dependents, your family does not need to satisfy any further medical Deductibles for the rest of that year.	*If satisfied HQ requirement* • $4,000 per family *If did not satisfy HQ requirement* • $4,250 per family(children only) • $4,500 per family (spouse, or spouse and children) After Non-Network Provider Deductibles totaling $4,000 (or higher) have been applied in a Calendar Year for either: • you and your Dependents, or • your Dependents, your family does not need to satisfy any further medical Deductible for the rest of that year.
Out-of-Pocket Maximums • Individual Out-of-Pocket Maximum	$4,000 per person	$8,000 per person
• Family Out-of-Pocket Maximum	$8,000 per family After Network Provider Out-of-Pocket Expenses totaling $8,000 have been incurred in a Calendar Year for either: • you and your Dependents, or • your Dependents, your family need not satisfy any further Out-of-Pocket Expenses for the rest of that year.	$16,000 per family After Non-Network Provider Out-of-Pocket Expenses totaling $16,000 have been incurred in a Calendar Year for either: • you and your Dependents or • your Dependents, your family need not satisfy any further Out-of-Pocket Expenses for rest of year.

Out-of-Pocket Expenses
Out-of-Pocket Expenses are expenses for Covered Services from Network Providers and Non-Network Providers for which no payment is provided because of the Co-payments, Deductible and Co-insurance. However, Charges for Covered Services incurred for or in connection with Non-Network Providers in excess of the Reasonable charges or Inpatient Hospital deductibles will not accumulate toward the Out-of-Pocket Maximums.

Simultaneous Accumulation of Deductibles and Out-of-Pocket Maximums
Charges incurred for Covered Services from either Network or Non-Network Providers will be used to satisfy both the Network Provider Deductible and Out-of-Pocket Maximum and the Non-Network Provider Deductible and Out-of-Pocket Maximum simultaneously, until the Network Provider Deductible and Out-of-Pocket Maximum have been satisfied. However, only Charges made by Non-Network Providers will be used to satisfy the remainder of the Non-Network Provider Deductible and Out-of-Pocket Maximum.

Co-Payments, amounts applied toward your Deductible, and any Co-insurance from eligible charges will be used to satisfy your Out-of-Pocket Maximum. Your Out-of-Pocket Maximum can be satisfied by eligible charges from the medical plan as well as the behavioral health plan. Any charges in excess of the Maximum Allowance and any hospital admission co-payments for Non-Participating Providers cannot be used to satisfy your Out-of-Pocket Maximum.

How this Plan Works:

	Network Provider	Non-Network Provider
Benefits for care other than for mental health and substance abuse	You and your Dependent are responsible for the Network Provider Co-payments, the Network Provider Deductible shown below plus the Co-insurance, then the Plan pays the benefit percentage shown.	You and your Dependent are responsible for the Non-Network Provider Deductible shown below plus the Co-insurance, then the Plan pays the benefit percentage shown.

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Physician Services • Primary Care Physician office visit • Specialist Physician office visit • Surgery performed in the Physician's office • Allergy Treatment/ Injections • Allergy serum (dispensed by the Physician in the office)	• Plan pays 100% after a $30 Co-payment per visit • Plan pays 100% after a $50 Co-payment per visit • Plan pays 80% after the Deductible • Plan pays 100% • Plan pays 100%	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible
Well Child Care (under age 16) • Includes charges for office visits, age-appropriate immunizations and routine diagnostic tests. There is a one visit per year maximum for children age 2 and older.	Plan pays 100% *Plan pays 100% for X-ray/lab services billed by a separate Outpatient diagnostic facility as long as these services were rendered in the office of a network provider*	Plan pays 100% up to $100 calendar year maximum for all services (office visits, exams and tests)
Well Adult care (age 16 & over) • One well person exam annually, including charges for an office visit, routine mammogram, pap smear, prostate exam, routine blood work and colorectal screening for cancer • Colonoscopy (covered once every three years for Participants age 45 and older)	• Plan pays 100% *Plan pays 100% for X-ray/lab services billed by a separate Outpatient diagnostic facility as long as these services were rendered in the office of a network provider* • Plan pays 100%	•Plan pays 100% up to $100 calendar year maximum for all services (office visits, exams and tests) • Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Pre-Admission Testing • Primary Care Physician office visit • Specialist Physician office visit • Outpatient facility • Independent lab and X-ray facility	• Plan pays 100% after a $30 Co-payment • Plan pays 100% after a $50 Co-payment • Plan pays 80% after the Deductible • Plan pays 100%	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible
Inpatient Hospital facility services • Semi-private room and board • Private room and board • Special care units (ICU/CCU room and board)	Plan pays 80% after the Deductible • Limited to the Hospital's negotiated rate, with the Claims Administrator, for a semi-private room • Limited to the Hospital's negotiated rate, with the Claims Administrator for a semi-private room • Limited to the Hospital's negotiated rate with the Claims Administrator	$200 Co-payment per admission then the Plan pays 60% after the Plan deductible • Limited to the Hospital's most common daily rate for a semi-private room • Limited to the Hospital's most common daily rate for a semi-private room • Limited to the Hospital's most common daily rate for an ICU/CCU room
Outpatient Hospital facility services Operating Room, Recovery room, Procedure Room and Treatment	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Inpatient Hospital Doctor's Visits/Consultations	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Inpatient Hospital Professional Services (e.g., Surgeon, Radiologist, Pathologist, Anesthesiologist)	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Outpatient Professional Services (e.g., Surgeon, Radiologist, Pathologist, Anesthesiologist)	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Second Opinions: *Services will be provided on a voluntary basis* • Primary Care Physician office visit • Specialist Physician Office Visit	• Plan pays 100% after a $30 Co-payment • Plan pays 100% after a $50 Co-payment	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible
Emergency and Urgent Care Services • Primary Care Physician Office Visit • Specialist Office Visit • Hospital Emergency Room • Urgent Care Facility or Outpatient Facility • Ambulance *In order to be covered, these services must be rendered as a result of a true emergency as defined in the Plan*	• Plan pays 100% after a $30 Co-payment per visit • Plan pays 100% after a $50 Co-payment per visit • Plan pays 100% after a $200 Co-payment* per visit** • Plan pays 100% after a $100 Co-payment* per visit** • 80% after Deductible ** Waived if admitted* ***If not a true emergency as defined in the Plan, the Plan pays 80% after the Deductible.*	• Plan pays 100% after a $30 Co-payment per visit** • Plan pays 100% after a $50 Co-payment per visit** • Plan pays 100% after a $200 Co-payment* per visit** • Plan pays 100% after a $100 Co-payment* per visit** • 80% after Deductible ** Waived if admitted* *** If not a true emergency as defined in the Plan, the Plan pays 60% after the Deductible*
Inpatient Services at Other Health Care Facilities (e.g., Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute facilities) Calendar Year Maximum: 120 days	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Laboratory and Radiology Services • MRIs, MRAs, CAT Scans and PET Scans • Other Laboratory and Radiology Services *All charges billed by an independent facility*	• Plan pays 80% after the Deductible • Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible
Home Health Care Calendar Year Maximum: 60 visits	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Private Duty Nursing Annual Maximum: $24,000	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Hospice • Inpatient Facility • Outpatient Facility • Hospice Room and Board Calendar Year Maximum: None	• Plan pays 80% after the Deductible • Plan pays 80% after the Deductible • Limited to the hospice facility's negotiated rate with the Claims Administrator	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Limited to the hospice facility's most common daily rate for a semi-private room
Bereavement Counseling • Inpatient Facility • Outpatient Services *Limited to three counseling sessions withinone1 year of decedent's death*	• Plan pays 80% after the Deductible for Services provided as part of the Hospice Care Program • Plan pays 80% after the Deductible for Services provided as part of the Hospice Care Program	• Plan pays 60% after the Deductible for Services provided as part of the Hospice Care Program • Plan pays 60% after the Deductible for Services provided as part of the Hospice Care Program

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Outpatient Short-Term Rehabilitative Therapy Includes: • Physical therapy • Occupational therapy Combined annual maximum: $6,000 • Speech therapy Annual maximum: $4,000 *In addition, there is a 20-visit calendar year maximum for speech therapy for pervasive development disorders in relation to serious mental illness (SMI)*	• Plan pays 100% after a $30 Co-payment • Plan pays 100% after a $30 Co-payment • Plan pays 100% after a $30 Co-payment	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible
Alternative Therapy Includes: • Chiropractic care • Massage therapy • Acupuncture • Naprapathy Combined annual maximum: $1,000	• Plan pays 100% after a $30 Co-payment • Plan pays 50%, no Deductible • Plan pays 50%, no Deductible • Plan pays 50%, no Deductible	• Plan pays 50% after the Deductible • Plan pays 50%, no Deductible • Plan pays 50%, no Deductible • Plan pays 50%, no Deductible
Maternity • Initial visit to confirm pregnancy • All subsequent Physician's Charges for prenatal visits, postnatal visits and delivery • Facility Charges (Inpatient Hospital, birthing center)	• Plan pays 100% after a $30 Co-payment • Plan pays 80% after the Deductible • Same as Plan's Inpatient Hospital facility benefit (No Deductible for newborn)	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Same as Plan's Inpatient Hospital facility benefit

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Abortion (Non-elective procedures only) • Inpatient Facility • Outpatient Facility • Physician's Services	• Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 80% after the Deductible	• Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 60% after the Deductible
Family Planning Office visits including tests and counseling • Primary Care Physician • Specialist physician	• Plan pays 100% after a $30 Co-payment per visit • Plan pays 100% after a $50 Co-payment per visit	• •Plan pays 60% after the Deductible • Plan pays 60% after the Deductible
Surgical Sterilization Procedures for Vasectomy/ Tubal Ligation (excluding reversals) • Inpatient facility • Outpatient facility • Physician's services	• Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 80% after the Deductible	• Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Infertility Treatment Office Visit (includes tests and counseling)		
• Primary Care Physician	• Plan pays 100% after a $30 Co-payment per visit	• Plan pays 60% after the Deductible
• Specialist Physician	• Plan pays 100% after a $50 Co-payment per visit	• Plan pays 60% after the Deductible
• Surgical treatment (i.e., procedures for correction of infertility, In Vitro Fertilization, Artificial Insemination, GIFT and ZIFT)		
• Inpatient Facility	• Same as Plan's Inpatient Hospital facility benefit	• Same as Plan's Inpatient Hospital facility benefit
• Outpatient Facility	• Same as Plan's Outpatient Hospital facility benefit	• Same as Plan's Outpatient Hospital facility benefit
• Physician's Services	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
Organ Transplants (Includes all medically appropriate non-experimental transplants)		
• UnitedHealthcare United Resource Network (URN) Center facility	• Plan pays 80% after the Deductible	• Not covered
• UnitedHealthcare United Resource Network (URN) Center Physician	• Plan pays 80% after the Deductible	• Not covered
• Travel services maximum *Covered only when transplant procedure is performed at a UnitedHealthcare United Resource Network (URN) Center facility)*	• $10,000 per transplant; any daily limitation is subject to IRS regulations	• Not covered
Durable Medical Equipment Calendar Year Maximum: $10,000 (excluding life-sustaining equipment)	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
External prosthetic appliances • Calendar Year Maximum: $10,000 *This benefit includes coverage for Cranial prosthetics with a separate lifetime maximum of $1,000 for wigs if you have received radiation therapy and/or chemotherapy*	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Hearing Benefits • Hearing exam and evaluation • Hearing aid (excludes replacement and repair)	• Plan pays 100% after a $50 Co- payment • Plan pays 50% up to $500 per ear every 24 months (no Deductible)	• Plan pays 60% after the Deductible • Plan pays 50% up to $500 per ear every 24 months (no Deductible)
Dental care (Limited to charges made for a continuous course of dental treatment started within six months of an Injury to sound, natural teeth) • Physician's Office Visit • Inpatient facility • Outpatient facility • Physician services	• Plan pays 100% after a $50 Co- payment • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Temporomandibular Joint Disorder (Surgical and Non-Surgical Treatment) • Office Visit • Inpatient Facility • Outpatient Facility • Physician services	• Plan pays 100% after a $50 Co-payment • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 60% after the Deductible
Licensed Dietitian • Office Visit	• Plan pays !00% after a $30 Co-payment	• Plan pays 100% after a $30 Co-payment

THE SCHEDULE — CONSUMER-DRIVEN HEALTH PLAN (CDHP)

General Overview

A consumer-driven health plan (CDHP) is a type of health insurance plan that allows a participant to use a health reimbursement account (HRA), explained below, to pay certain health care expenses directly, while a high-deductible health plan protects the participant from catastrophic medical expenses.

An employer/plan-funded health reimbursement arrangement (HRA, also called a health reimbursement account) is used to offset eligible unreimbursed expenses incurred by the participant or covered eligible dependents. If a participant does not use all HRA funds during a calendar year, the remaining amount will roll over to the following year, with no cap on accumulated rolled-over funds.

HRAs are described more fully in *IRS Notice 2002-45.* Contributions to the HRA from the Plan and your Plan Sponsor generally are not taxable. A participant cannot make any contributions to an HRA

HRA balances remaining at the time of retirement may be used to the extent allowed under the law for eligible health care-related expenses, including retirement medical products and plans outside of HealthFlex. To be eligible, the participant must satisfy the retiree eligibility rules of both HealthFlex and his/her plan sponsor (conference or employer). The HRA balance will be available for the participant's use even if the plan sponsor does not sponsor retiree health coverage through HealthFlex.

For active participants and their dependents, all flexible spending account (FSA)-eligible expenses may be reimbursed from HRA funds.

Participants may combine a medical FSA (also called the "medical reimbursement account" or "MRA") with an HRA. Based on the plan design, the FSA always pays first; then the HRA pays. FSA dollars are subject to the "use it or lose it" rule, so you risk losing your unspent FSA dollars at the end of a plan year and grace period. In contrast, HRA dollars can roll over from year to year if they are not spent.

For You and Your Dependents

This Plan provides medical benefits for services and supplies provided by Network Providers and Non-Network Providers, unless otherwise noted. You will be required to pay a portion of the Charges for most Covered Services whether or not those services were rendered by Network or Non-Network Providers. That portion is the Co-payment, Deductible or Co-insurance. You or your Dependent can obtain the names of Network Providers in your area by visiting the website **www.gbophb.org**, logging into HealthFlex/WebMD and accessing the UnitedHealthcare Web page under "HealthFlex Vendor Links," or by calling the toll-free number shown on the back of your ID Card.

Co-Insurance

The term Co-insurance means the percentage of Charges for Covered Services that a Participant is required to pay under the Plan.

Co-Payments/Deductibles
Co-payments are expenses to be paid by you or your Dependent for Covered Services received. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Co-payments. Co-payments and Deductibles must be paid in addition to any Co-insurance.

Plan Pays:

Plan Maximum Benefits	Network Provider	Non-Network Provider
Lifetime Maximum	None	None

You Pay:

Deductibles	Network Provider	Non-Network Provider
Individual Deductible	*If HQ requirement satisfied* • $2,000 per person *If HQ requirement not satisfied* • $2,250 per person	*If HQ requirement satisfied* • $3,000 per person *If HQ requirement not satisfied* • $3,250 per person
Family Deductible	*If HQ requirement satisfied* • $4,000 per family *If HQ requirement not satisfied* • $4,250 per family (children only) • $4,500 per family (spouse, or spouse and children) After Network Provider Deductibles totaling $4,000 (or higher) have been applied in a Calendar Year for either: • you and your Dependents, or • your Dependents, your family does not need to satisfy any further medical Deductibles for the rest of that year.	*If HQ requirement satisfied* • $6,000 per family *If HQ requirement not satisfied* • $6,250 per family (children only) • $6,500 per family (spouse, or spouse and children) After Non-Network Provider Deductibles totaling $6,000 (or higher) have been applied in a Calendar Year for either: • you and your Dependents, or • your Dependents, your family does not need to satisfy any further medical Deductible for the rest of that year.
Out-of-Pocket Maximums • Individual Out-of-Pocket Maximum	$5,000 per person	$9,000 per person
• Family Out-of-Pocket Maximum	$10,000 per family After Network Provider Out-of-Pocket Expenses totaling $10,000 have been incurred in a Calendar Year for either: • you and your Dependents, or • your Dependents, your family does not need to satisfy any further Out-of-Pocket Expenses for the rest of that year.	$18,000 per family After Non-Network Provider Out-of-Pocket Expenses totaling $18,000 have been incurred in a Calendar Year for either: • you and your Dependents or • your Dependents, your family does not need to satisfy any further Out-of-Pocket Expenses for the rest of that year.

Out-of-Pocket Expenses
Out-of-Pocket Expenses are expenses for Covered Services from Network Providers and Non-Network Providers for which no payment is provided because of the Co-payments, Deductible and Co-insurance. However, Charges for Covered Services incurred for or in connection with Non-Network Providers in excess of the Reasonable charges or Inpatient Hospital deductibles will not accumulate toward the Out-of-Pocket Maximums.

Simultaneous Accumulation of Deductibles and Out-of-Pocket Maximums
Charges incurred for Covered Services from either Network or Non-Network Providers will be used to satisfy both the Network Provider Deductible and Out-of-Pocket Maximum and the Non-Network Provider Deductible and Out-of-Pocket Maximum simultaneously, until the Network Provider Deductible and Out-of-Pocket Maximum have been satisfied. However, only Charges made by Non-Network Providers will be used to satisfy the remainder of the Non-Network Provider Deductible and Out-of-Pocket Maximum.

Co-Payments, amounts applied toward your Deductible, and any Co-insurance from eligible charges will be used to satisfy your Out-of-Pocket Maximum. Your Out-of-Pocket Maximum can be satisfied by eligible charges from the medical plan as well as the behavioral health plan. Any charges in excess of the Maximum Allowance and any hospital admission co-payments for Non-Participating Providers cannot be used to satisfy your Out-of-Pocket Maximum.

How this Plan Works:

	Network Provider	Non-Network Provider
Benefits for care other than for mental health and substance abuse	You and your Dependent are responsible for the Network Provider Deductible shown below plus the Co-insurance plus any applicable Co-payments; then the Plan pays the benefit percentage shown.	You and your Dependent are responsible for the Non-Network Provider Deductible shown below plus the Co-insurance; then the Plan pays the benefit percentage shown.

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Physician Services • Primary Care Physician office visit • Specialist Physician office visit • Surgery performed in the Physician's office • Allergy Treatment/Injections • Allergy serum (dispensed by the Physician in the office)	• Plan pays 80% after the Deductible • Plan pays 80% after the Deductible • Plan pays 80% after the Deductible • Plan pays 80% after the Deductible • Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible
Well Child Care (under age 16) • Includes charges for office visits, age-appropriate immunizations and routine diagnostic tests. There is a one visit per year maximum for children age 2 and older.	Plan pays 100% *Plan pays 100% for X-ray/lab services billed by a separate Outpatient diagnostic facility as long as these services were rendered in the office of a network provider*	Plan pays 100% up to $100 calendar year maximum for all services (office visits, exams and tests)
Well adult care (age 16 & over) • One well person exam annually, including charges for an office visit, routine mammogram, pap smear, prostate exam, routine blood work and colorectal screening for cancer • Colonoscopy (covered once every three years for Participants age 45 and older)	• Plan pays 100% *Plan pays 100% for X-ray/lab services ~~if~~ billed by a separate Outpatient diagnostic facility as long as these services were rendered in the office of a network provider* • Plan pays 100%	•Plan pays 100% up to $100 calendar year maximum for all services (office visits, exams, and tests) • Plan pays 60% after the Deductible

Plan Pays:

Deductibles	Network Provider	Non-Network Provider
Pre-admission testing		
• Primary Care Physician office visit	• Plan pays 80% after the Deductible	•Plan pays 60% after the Deductible
• Specialist Physician office visit	• Plan pays 80% after the Deductible	•Plan pays 60% after the Deductible
• Outpatient facility	•Plan pays 80% after the Deductible	•Plan pays 60% after the Deductible
• Independent lab and x-ray facility	• Plan pays 80% after the Deductible	•Plan pays 60% after the Deductible
Inpatient Hospital facility services	Plan pays 80% after the Deductible	$200 Co-payment per admission then the Plan pays 60% after the Plan deductible
• Semi-private room and board	•Limited to the Hospital's negotiated rate, with the Claims Administrator, for a semi-private room	•Limited to the Hospital's most common daily rate for a semi-private room
• Private room and board	•Limited to the Hospital's negotiated rate, with the Claims Administrator, for a semi-private room	•Limited to the Hospital's most common daily rate for a semi-private room
• Special care units (ICU/CCU room and board)	•Limited to the Hospital's negotiated rate with the Claims Administrator	•Limited to the Hospital's most common daily rate for an ICU/CCU room
Outpatient Hospital facility services Operating Room, Recovery room, Procedure Room and Treatment	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Inpatient Hospital Doctor's Visits/Consultations	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Inpatient Hospital Professional Services (e.g., Surgeon, Radiologist, Pathologist, Anesthesiologist)	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Outpatient Professional Services (e.g., Surgeon, Radiologist, Pathologist, Anesthesiologist)	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Second Opinions: Services will be provided on a voluntary basis • Primary Care Physician office visit • Specialist Physician office visit	• Plan pays 80% after the Deductible • Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible
Emergency and Urgent Care Services • Primary Care Physician Office Visit • Specialist Office Visit • Hospital Emergency Room • Urgent Care Facility or Outpatient Facility • Ambulance *In order to be covered, these services must be rendered as a result of a true emergency as defined in the Plan*	• Plan pays 80% after the Deductible • Plan pays 80% after the Deductible • Plan pays 80% after the Deductible • Plan pays 80% after the Deductible • Plan pays 80% after Deductible	• Plan pays 80% after the Deductible* • Plan pays 80% after the Deductible * • Plan pays 80% after the Deductible* • Plan pays 80% after the Deductible* • Plan pays 80% after Deductible ** If not a true emergency as defined in the Plan, the Plan pays 60% after the Deductible*
Inpatient Services at Other Health Care Facilities (e.g., Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute facilities) Calendar Year Maximum: 120 days	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
<u>Laboratory and Radiology Services</u> • MRIs, MRAs, CAT Scans and PET Scans • Other Laboratory and Radiology Services (All charges billed by an independent facility)	• Plan pays 80% after the Deductible • Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Home Health Care Calendar Year Maximum: 60 visits	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Private Duty Nursing Annual Maximum: $24,000	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Hospice • Inpatient Facility • Outpatient Facility • Hospice Room and Board Calendar Year Maximum: None	• Plan pays 80% after the Deductible • Plan pays 80% after the Deductible • Limited to the hospice facility's negotiated rate with the Claims Administrator	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Limited to the hospice facility's most common daily rate for a semi-private room
Bereavement Counseling • Inpatient Facility • Outpatient Services *Limited to three counseling sessions within one year of decedent's death*	• Plan pays 80% after the Deductible for Services provided as part of the Hospice Care Program • Plan pays 80% after the Deductible for Services provided as part of the Hospice Care Program	• Plan pays 60% after the Deductible for Services provided as part of the Hospice Care Program • Plan pays 60% after the Deductible for Services provided as part of the Hospice Care Program

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Outpatient Short-Term Rehabilitative Therapy Includes: • Physical therapy • Occupational therapy Combined annual maximum: $6,000 • Speech therapy Annual maximum: $4,000 *In addition, there is a 20-visit calendar year maximum for speech therapy for pervasive development disorders in relation to serious mental illness (SMI)*	• Plan pays 80% after the Deductible • Plan pays 80% after the Deductible • Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Plan pays 60% after the Deductible
Alternative Therapy Includes: • Chiropractic care • Massage therapy • Acupuncture • Naprapathy *Combined annual maximum: $1,000*	• Plan pays 80% after the Deductible • Plan pays 50%, no Deductible • Plan pays 50%, no Deductible • Plan pays 50%, no Deductible	• Plan pays 50% after the Deductible • Plan pays 50%, no Deductible • Plan pays 50%, no Deductible • Plan pays 50%, no Deductible

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Maternity • Initial visit to confirm pregnancy • All subsequent Physician's Charges for prenatal visits, postnatal visits and delivery • Facility Charges (Inpatient Hospital, birthing center)	• Plan pays 80% after the Deductible • Plan pays 80% after the Deductible • Same as Plan's Inpatient Hospital facility benefit (No Deductible for newborn)	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible • Same as Plan's Inpatient Hospital facility benefit
Abortion (Non-elective procedures only) • Inpatient facility • Outpatient facility • Physician's services	• Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 80% after the Deductible	• Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 60% after the Deductible
Family Planning Office visits including tests and counseling • Primary Care Physician • Specialist Physician	• Plan pays 80% after the Deductible • Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible • Plan pays 60% after the Deductible
Surgical Sterilization Procedures for Vasectomy/ Tubal Ligation (excluding reversals) • Inpatient facility • Outpatient facility • Physician's services	• •Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 80% after the Deductible	• Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Infertility Treatment Office Visit (includes tests and counseling)		
• Primary Care Physician	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
• Specialist Physician	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
Surgical treatment (i.e., procedures for correction of infertility, In Vitro Fertilization, Artificial Insemination, GIFT and ZIFT)		
• Inpatient facility	• Same as Plan's Inpatient Hospital facility benefit	• Same as Plan's Inpatient Hospital facility benefit
• Outpatient facility	• Same as Plan's Outpatient Hospital facility benefit	• Same as Plan's Outpatient Hospital facility benefit
• Physician's services	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
Organ Transplants (Includes all medically appropriate non-experimental transplants)		
• UnitedHealthcare United Resource Network (URN) Center facility	• Plan pays 80% after the Deductible	• Not covered
• UnitedHealthcare United Resource Network (URN) Center physician	• Plan pays 80% after the Deductible	• Not covered
• Travel services maximum *Covered only when transplant procedure is performed at a UnitedHealthcare United Resource Network (URN) Center facility*	• $10,000 per transplant; any daily limitation is subject to IRS regulations	• Not covered
Durable Medical Equipment Calendar Year Maximum: $10,000 (excluding life-sustaining equipment)	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
External Prosthetic Appliances • Calendar Year Maximum: $10,000 *This benefit includes coverage for cranial prosthetics with a separate lifetime maximum of $1,000 for wigs if you have received radiation therapy and/or chemotherapy*	Plan pays 80% after the Deductible	Plan pays 60% after the Deductible
Hearing Benefits • Hearing exam and evaluation • Hearing aid (excludes replacement and repair)	• Plan pays 80% after the Deductible • Plan pays 50% up to $500 per ear every 24 months (no Deductible)	• Plan pays 60% after the Deductible • Plan pays 50% up to $500 per ear every 24 months (no Deductible)
Dental Care (Limited to charges made for a continuous course of dental treatment started within six months of an Injury to sound, natural teeth) • Physician's office visit • Inpatient facility • Outpatient facility • Physician services	• Plan pays 80% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible • Same as Plan's Inpatient Hospital facility benefit • Same as Plan's Outpatient Hospital facility benefit • Plan pays 60% after the Deductible

Plan Pays:

Plan Feature	Network Provider	Non-Network Provider
Temporomandibular Joint Disorder (Surgical and Non-Surgical Treatment)		
• Office visit	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
• Inpatient facility	• Same as Plan's Inpatient Hospital facility benefit	• Same as Plan's Inpatient Hospital facility benefit
• Outpatient facility	• Same as Plan's Outpatient Hospital facility benefit	• Same as Plan's Outpatient Hospital facility benefit
• Physician services	• Plan pays 80% after the Deductible	• Plan pays 60% after the Deductible
Licensed Dietitian		
• Office visit	• Plan pays 80% after the Deductible	• Plan pays 80% after the Deductible

Prescription Drug Benefits Schedules

FIXED CO-PAYMENT PLAN 2 (FX 2) — THE SCHEDULE

This Schedule provides Prescription Drug benefit highlights and a basic description of how this Plan works for you and your Dependents.

Pharmacy Benefits:

- ***Participating Pharmacy:*** You or your Dependent must pay a portion of the cost of covered Prescription Drugs. That portion is described below.
- ***Non-Participating Pharmacy:*** You or your Dependent must pay a portion of the cost of covered Prescription Drugs. That portion is described below.

Calendar Year Deductible

Deductibles are expenses to be paid by you or your Dependent for covered Prescription Drugs purchased at a Retail Pharmacy. These Deductibles are in addition to any Co-payments. This Deductible does not apply to Medco Pharmacy purchases (i.e., Medco's mail-order pharmacy).

Deductibles	Participating Pharmacy	Non-Participating Pharmacy
Individual	$100 per person per Calendar Year	$100 per person per Calendar Year
Family	$200 per family per Calendar Year After Prescription Drug Deductibles totaling $200 have been applied in a Calendar Year for either: • you or your Dependent, or • your Dependents, your family does not need to satisfy any further Prescription Drug Deductible for the rest of that Calendar Year.	$200 per family per Calendar Year After Prescription Drug Deductibles totaling $200 have been applied in a Calendar Year for either: • you or your Dependent, or • your Dependents, your family does not need to satisfy any further Prescription Drug Deductible for the rest of that Calendar Year.

Out-of-Pocket Expenses
Out-of-Pocket Expenses are expenses incurred for covered Prescription Drugs provided by Participating and Non-Participating Pharmacies for which no payment is provided because of any Co-payment.

Out-of-Pocket Expenses exclude Co-payments for Tier 3 Drugs, non-preferred generic drugs, cost differences incurred as a result of the Generic First Program, retail Deductibles, and expenses incurred at Non-Participating Pharmacies that exceed the amount payable at a Participating Pharmacy.

Out-of-Pocket Maximum	Participating Pharmacy	Non-Participating Pharmacy
Individual	$2,500 per person per Calendar Year	None
Family	$5,000 per family per Calendar Year	None

Retail Pharmacy Benefits
- ***Retail Refill Allowance (RRA) Program:*** Participants will be allowed to obtain three fills (the initial fill plus two refills) of maintenance drugs at a Participating Retail Pharmacy. For all subsequent fills at a Participating Retail Pharmacy, Participants will be responsible for paying 100% of the discounted cost.
- ***Prescription Drug Maximum:*** No more than a 30-day supply per retail prescription order or refill.
- ***Reimbursement for Non-Participating Pharmacy or a Participating Pharmacy when no UnitedHealthcare ID card is used*** is limited to the amount the Plan would have paid to a Participating Pharmacy. If a Participating Pharmacy is not available, a Claim must be filed on a paper form available from Medco; then 100% of the Allowable Amount will be reimbursed after Deductible and Co-Payment are met.

	Participating Pharmacy	Non-Participating Pharmacy
Prescription Drugs		
• Generic Drugs* (Tier 1)	• After the Retail Deductible has been satisfied, the Plan pays 100% after a $10 Co-payment per prescription	• See above
• Preferred Brand Name Drugs** (Tier 2)	• After the Retail Deductible has been satisfied, the Plan pays 100% after a $20 Co-payment per prescription	• See above
• Non-Preferred Brand Name Drugs** (Tier 3)	• After the Retail Deductible has been satisfied, the Plan pays 100% after a $35 Co-payment per prescription	• See above

*** Generic Drugs:** While the majority of generic drugs are considered "preferred generic," some generic drugs are considered "non-preferred." While the Co-payment is the same for preferred and non-preferred generics, Co-payments associated with non-preferred generics do not apply to the Out-of-pocket Maximum

**** Generic First Program:** When the Brand Name Drug is chosen when an equivalent Generic Drug is available, the Participant is required to pay an amount equal to the Generic Drug Co-payment plus the difference in cost between the Generic Drug and the Brand Name Drug.

Medco Pharmacy Benefits
Prescription Drug Maximum: No more than a 90-day supply per prescription order or refill.

	Participating Pharmacy	Non-Participating Pharmacy
Home Delivered Drugs		
• Generic Drugs (Tier 1)	• Plan pays 100% after a $20 Co-payment per prescription	• Not applicable
• Preferred Brand Name Drugs* (Tier 2)	• Plan pays 100% after a $50 Co-payment per prescription	• Not applicable
• Non-Preferred Brand Name Drugs* (Tier 3)	• Plan pays 100% after a $88 Co-payment per prescription	• Not applicable

*** Generic First Program:** When the Brand Name Drug is chosen when an equivalent Generic Drug is available, the Participant is required to pay an amount equal to the Generic Drug Co-payment plus the difference in cost between the Generic Drug and the Brand Name Drug.

PERCENTAGE CO-PAYMENT PLAN 1 (P 1) — THE SCHEDULE

This Schedule provides Prescription Drug benefit highlights and a basic description of how this Plan works for you and your Dependents.

Pharmacy Benefits:

- ***Participating Pharmacy:*** You or your Dependent must pay a portion of the cost of covered Prescription Drugs. That portion is described below.
- ***Non-Participating Pharmacy:*** You or your Dependent must pay a portion of the cost of covered Prescription Drugs. That portion is described below.

Calendar Year Deductible

Deductibles	Participating Pharmacy	Non-Participating Pharmacy
Individual	Does not apply	Does not apply
Family	Does not apply	Does not apply

Out-of-Pocket Expenses

Out-of-Pocket Expenses are expenses incurred for covered Prescription Drugs provided by Participating and Non-Participating Pharmacies in excess of any participant Co-payment. Out-of-Pocket Expenses exclude Co-payments for Tier 3 Drugs, non-preferred generic drugs, cost differences incurred as a result of the Generic First Program, retail Deductibles, and expenses incurred at Non-Participating Pharmacies that exceed the amount payable at a Participating Pharmacy.

Out-of-Pocket Maximum	Participating Pharmacy	Non-Participating Pharmacy
Individual	$2,000 per person per Calendar Year	None
Family	$4,000 per family per Calendar Year	None

Retail Pharmacy Benefits

- ***Retail Refill Allowance (RRA) Program:*** Participants will be allowed to obtain three fills (the initial fill plus two refills) of maintenance drugs at a Participating Retail Pharmacy. For all subsequent fills at a Participating Retail Pharmacy, Participants will be responsible for paying 100% of the discounted cost
- ***Prescription Drug Maximum:*** No more than a 30-day supply per retail prescription order or refill.
- ***Reimbursement for Non-Participating Pharmacy or a Participating Pharmacy when no UnitedHealthcare ID card is used*** is limited to the amount the Plan would have paid a Participating Pharmacy. If a Participating Pharmacy is not available, a Claim must be filed on a paper form available from Medco; then 100% of the Allowable Amount will be reimbursed after Deductible and Co-Payment are met.

	Participating Pharmacy	Non-Participating Pharmacy
Prescription Drugs		
• Generic Drugs* (Tier 1)	• Plan pays 100% after a $12 Co-payment per prescription	• See above
• Preferred Brand Name Drugs** (Tier 2)	• Plan pays 100% after a 20% Co-payment per prescription. Minimum Co-payment: $15 Maximum Co-payment: $45	• See above
• Non-preferred Brand Name Drugs** (Tier 3)	• Plan pays 100% after a 25% Co-payment per prescription. Minimum Co-payment: $30 Maximum Co-payment: $90	• See above

*** Generic Drugs: While** the majority of generic drugs are considered "preferred generic," some generic drugs are considered "non-preferred." While the Co-payment is the same for preferred and non-preferred generics, Co-payments associated with non-preferred generics do not apply to the Out-of-Pocket Maximum.

**** Generic First Program:** When the Brand Name Drug is chosen when an equivalent Generic Drug is available, the Participant is required to pay an amount equal to the Generic Drug Co-payment plus the difference in cost between the Generic Drug and the Brand Name Drug.

Medco Pharmacy Benefits

Prescription Drug Maximum: No more than a 90-day supply per prescription order or refill.

	Participating Pharmacy	Non-Participating Pharmacy
Home Delivered Drugs		
• Generic Drugs (Tier 1)	• Plan pays 100% after a $20 Co-payment per prescription	• Not applicable
• Preferred Brand Name Drugs* (Tier 2)	• Plan pays 100% after a 20% Co-payment per prescription. Minimum Co-payment: $40; Maximum Co-payment: $120	• Not applicable
• Non-preferred Brand Name Drugs* (Tier 3)	• Plan pays 100% after a 25% Co-payment per prescription. Minimum Co-payment: $75; Maximum Co-payment: $225	• Not applicable

*** Generic First Program:** When the Brand Name Drug is chosen when an equivalent Generic Drug is available, the Participant is required to pay an amount equal to the Generic Drug Co-payment plus the difference in cost between the Generic Drug and the Brand Name Drug.

PERCENTAGE CO-PAYMENT PLAN 2 (P 2): THE SCHEDULE

This Schedule provides Prescription Drug benefit highlights and a basic description of how this Plan works for you and your Dependents.

Pharmacy Benefits:

- ***Participating Pharmacy:*** You or your Dependent must pay a portion of the cost of covered Prescription Drugs. That portion is described below.
- ***Non-Participating Pharmacy:*** You or your Dependent must pay a portion of the cost of covered Prescription Drugs. That portion is described below.

Calendar Year Deductible

Deductibles	Participating Pharmacy	Non-Participating Pharmacy
Individual	Does not apply	Does not apply
Family	Does not apply	Does not apply

Out-of-Pocket Expenses

Out-of-Pocket Expenses are expenses incurred for covered Prescription Drugs provided by Participating and Non-Participating Pharmacies in excess of any participant Co-payment. ` Out-of-Pocket Expenses exclude Co-payments for Tier 3 Drugs, non-preferred generic drugs, cost differences incurred as a result of the Generic First Program, retail Deductibles, and expenses incurred at Non-Participating Pharmacies that exceed the amount payable at a Participating Pharmacy.

Out-of-Pocket Maximum	Participating Pharmacy	Non-Participating Pharmacy
Individual	$2,500 per person per Calendar Year	None
Family	$5,000 per family per Calendar Year	None

Retail Pharmacy Benefits

- ***Retail Refill Allowance (RRA) Program:*** Participants will be allowed to obtain three fills (the initial fill plus two refills) of maintenance drugs at a Participating Retail Pharmacy. For all subsequent fills at a Participating Retail Pharmacy, Participants will be responsible for paying 100% of the discounted cost.
- ***Prescription Drug Maximum:*** No more than a 30-day supply per retail prescription order or refill.
- ***Reimbursement for Non-Participating Pharmacy or a Participant Pharmacy when no UnitedHealthcare ID card is used*** is limited to the amount the Plan would have paid a Participating Pharmacy. If a Participating Pharmacy is not available, a Claim must be filed on a paper form available from Medco; then 100% of the Allowable Amount will be reimbursed after Deductible and Co-Payment are met.

	Participating Pharmacy	Non-Participating Pharmacy
Prescription Drugs		
• Generic Drugs* (Tier 1)	• Plan pays 100% after a $12 Co-payment per prescription	• See above
• Preferred Brand Name Drugs** (Tier 2)	• Plan pays 100% after a 25% Co-payment per prescription. Minimum Co-payment: $15 Maximum Co-payment: $45	• See above
• Non-preferred Brand Name Drugs** (Tier 3)	• Plan pays 100% after a 30% Co-payment per prescription. Minimum Co-payment: $30 Maximum Co-payment: $90	• See above

*** Generic Drugs: While** the majority of generic drugs are considered "preferred generic", some generic drugs are considered "non-preferred". While the co-pay is the same for preferred and non-preferred generics, co-pays associated with non-preferred generics do not apply to the out of pocket maximum

**** Generic First Program:** When the Brand Name Drug is chosen when an equivalent Generic Drug is available, the Participant is required to pay an amount equal to the Generic Drug Co-payment plus the difference in cost between the Generic Drug and the Brand Name Drug.

Medco PharmacyBenefits

Prescription Drug Maximum: No more than a 90-day supply per prescription order or refill.

	Participating Pharmacy	Non-Participating Pharmacy
Home Delivered Drugs		
• Generic Drugs (Tier 1)	• Plan pays 100% after a $20 Co-payment per prescription	• Not applicable
• Preferred Brand Name Drugs* (Tier 2)	• Plan pays 100% after a 25% Co-payment per prescription. Minimum Co-payment: $40 Maximum Co-payment: $120	• Not applicable
• Non-preferred Brand Name Drugs* (Tier 3)	• Plan pays 100% after a 30% Co-payment per prescription. Minimum Co-payment: $75 Maximum Co-payment $225	• Not applicable

*** Generic First Program:** When the Brand Name Drug is chosen when an equivalent Generic Drug is available, the Participant is required to pay an amount equal to the Generic Drug Co-payment plus the difference in cost between the Generic Drug and the Brand Name Drug.

Notes to Schedule of Prescription Drug Benefits—All Plans

Coverage of Non-Sedating Antihistamines: Non-sedating antihistamine drugs are paid as Tier 3, regardless of the drug's Formulary status. This is a result of the drug, Claritin, being available over-the-counter. For example, if you prefer to take the medication Clarinex rather than buying Claritin over-the-counter, you will pay the Tier 3 Co-payment.

Retail Refill Allowance (RRA) Program: The Plan will maintain a Retail Refill Allowance Program policy. This program requires that you use the Medco Pharmacy (i.e., Medco home delivery by mail) if you are prescribed a maintenance medication (long-term Prescription Drug), rather than refilling multiple prescriptions for the same Prescription Drug at a Retail Pharmacy.

Important: *If you or a covered Dependent receives a prescription for a maintenance medication and you do not use the Medco Pharmacy, your Prescription Drugs may not be covered.* Participants will be allowed to obtain three fills (the initial fill plus two refills) of maintenance Prescription Drugs at a Participating Retail Pharmacy. For all subsequent fills, Participants must use the Medco Pharmacy for the maintenance Prescription Drug to be covered. *Otherwise, the Participant will be responsible for paying 100% of the discounted cost of the Prescription Drug.*

In certain circumstances, you may not be required to use the Medco Pharmacy. For example, there are several categories of medications that are uniquely appropriate for multiple refills at your local Participating Retail Pharmacy (and are therefore exempt from the mandatory Medco Pharmacy provision that is outlined above). If you have a prescription for any of the following medications, the Plan allows you to receive multiple refills at your local Participating Retail Pharmacy:

- Anti-infectives, including antibiotics (Amoxicillin, Biaxin), antivirals (Zovirax, Famvir), antifungals (Diflucan), and drops used in the eyes and ears (Polsporin Opth, Cipro Otic). Please note that drops must be prescribed specifically to treat infection. For example, glaucoma drops are not covered.
- Prescription cough medications, including Phenergan with Codeine, Tessalon and Tussionex.
- Medications to treat acute pain, both narcotic (Vicodin, Percodan, etc.) and non-narcotic (Darvocet). Please note that long-term pain medications, such as NSAIDs, do not meet the necessary retail requirements.
- Medications that require a new written prescription each time you need them, as refills are prohibited by federal law (e.g., Percodan, Ritalin and Nembutal).
- Medications used to treat both attention deficit disorder (Ritalin, Cylert) and narcolepsy (Dexedrine).
- Medications whose sole use is to treat cancer.

Keep in mind that—with the exception of the drugs listed above—the Plan allows for only a total of three fills of a maintenance medication at a Participating Retail Pharmacy (one original fill and two refills). Additional fills will not be covered by the Plan; you will have to pay the full price of the drug. Each retail fill can be for no more than a 30-day supply. Note that you are allowed a total of three retail pharmacy fills, even if each is for less than 30 days.

Generic First Program: Generic medications may have unfamiliar names, but they are safe and effective. Generic medications and their Brand Name counterparts have the same active ingredients and are manufactured according to the same strict federal regulations. Generic drugs may differ in color, size or shape, but the U.S. Food and Drug Administration (FDA) requires that the active ingredients have the same strength, purity and quality as their Brand Name counterparts. For this reason, the Plan will cover only the cost of the equivalent Generic Drug if you purchase a Brand Name Drug when there is an equivalent Generic Drug available. You will be charged one amount equal to the Generic Drug Co-payment (for example, $7) plus the cost difference between the Brand Name Drug and the Generic Drug. If you have questions or concerns about generic medication, speak to your Physician or your Pharmacist, and he or she will be able to help you.

Refilling Medco Pharmacy (Medco by mail) Prescriptions: Because it can take 7 to 11 days for your medications to be delivered, you should have at least a 14-day supply of that medication on hand to hold you over. If you do not have enough medication, you may need to ask your Physician for another prescription for a 14-day supply that you can fill at your local Participating Retail Pharmacy (note that you will be responsible for paying any applicable Retail Pharmacy Co-payment).

Prescriptions Filled at a Non-Participating Pharmacy: If you go to a Retail Pharmacy that is not part of the Medco network (a Non-Participating Pharmacy), you must pay the full cost of the prescription and then submit a direct reimbursement Claim form to Medco. You will be reimbursed for the amount the medication would have cost the Plan at a Participating Retail Pharmacy minus the Co-payment you would have paid.

Medco Toll-Free Number: 1-800-841-2806

Additional Notes:

- Some prescriptions may require prior authorization. Please refer to the *Prescription Drug Benefits* section of this Benefit Booklet for further information.
- Deductibles and Co-payments for Prescription Drugs do not apply to the Plan Deductibles or Out-of-Pocket Maximums under the Medical portion of the Plan.