A Summary of Your Benefits Under the AFL-CIO Health & Welfare Plan – Fire Fighters

AFL-CIO Health & Welfare Plan – Fire Fighters

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Table of Contents

SECTION 1: General Information

Introduction

This booklet describes the benefits that are available to you as a Participant in the AFL-CIO Health & Welfare Plan – Fire Fighters (the "Plan"), and the conditions under which the benefits are available. Please read this booklet carefully so you will understand your coverage. If you have questions about this booklet or about the Plan (other than questions about a specific benefit or a specific claim), please contact the AFL-CIO Health & Welfare Plan Office, 333 West Vine St., Suite 500, Lexington, KY 40507 ("Plan Office"). You may also call the Plan Office toll-free at 877-423-5246 for assistance. Office hours are 8:00 AM to 5:00 PM Eastern Time, Monday through Friday. At other times, you may leave a message and your call will be returned as soon as possible. Information can also be found on the Plan web site at www.aflciotpa.org.

If you have questions about a particular benefit or an outstanding claim, you should contact the benefit provider directly at the toll-free number listed on your identification card.

This booklet is intended only to provide a summary of your benefits. The terms and conditions of the benefits available from the Plan are more fully discussed in the documents called the Certificates of Coverage. Each benefit under the Plan has a Certificate of Coverage issued by the insurance carrier. Please contact the Plan Office if you would like a copy of a Certificate of Coverage. If there are any contradictions between this booklet and the Certificates of Coverage, the terms of the Certificates of Coverage will govern.

What benefits are available from the Plan?

The Plan provides the following benefits:

- Medical Benefits
- Prescription Drug Benefits
- Dental Benefits
- Vision Benefits

- Life Insurance
- Accidental Death and Dismemberment Benefits

Not all Participants are eligible for all of the benefits offered. The Employer Participation Summary section of this booklet lists the benefits for which you are or may become eligible.

Whom do I contact with questions about benefits?

The identification card that you receive for each benefit, except for Life and Accidental Death and Dismemberment benefits, includes a toll-free phone number and an address for questions about that benefit, including whether a particular service is covered and questions about the status of your claim.

For questions about life and accidental death and dismemberment benefits, you should call the Plan Office. Also, for more general questions about the Plan, or if you are having problems getting a satisfactory answer to your questions about a benefit, please contact the Plan Office.

Plan Management

Who manages the Plan?

The Plan is managed by your Employer, who may engage other persons or entities, such as the Plan Office, to conduct the day-to-day operations. Your Employer fully intends to continue to maintain the Plan indefinitely. However, the Employer has the sole and absolute discretion to modify or terminate the Plan at any time.

What does the Plan Office do?

The Plan Office handles the day-to-day administrative functions for the Plan, including distributing this booklet and other information to you and your Dependents, responding to your requests about the Plan, and maintaining appropriate participant and employer information. You may contact the Plan Office with any questions that you have at the address or phone number set forth in the Introduction.

What role do Insurance Companies and other providers play?

Your Employer has contracted with insurance companies for the purchase of an insurance policies to pay benefits, or with an insurance company or other entity for the provision of administrative services for a particular benefit (such as to process claims). This booklet discusses the role that an insurance company or other entity plays, if any, with respect to a particular benefit. Because of these arrangements, if you contact the Plan Office with questions about a particular benefit, the Plan Office may in some cases refer you to an insurance carrier or other entity for an answer.

General Contact Information

The benefits described in this Summary Plan Description (SPD) are guaranteed under a contract of insurance issued to your Employer by the following insurance companies, each of which provides claims payment and other administrative services for the Plan. Below is the contact information for submitting claims; the back of your insurance card will also have the most current contact information.

Type of Claim	Claims Administrator
General: Care Coordination / Notification, Customer Service Representatives and 24-hour Optum® NurseLine	United Healthcare 800-996-0592 www.myUHC.com
Medical Claims	United Healthcare Insurance Company Attn: Claims PO Box 740800 Atlanta, GA 30374-0800
Requests for Review of Denied Medical Claims	United Healthcare Attn: Appeals PO Box 30573 Salt Lake City, UT 84130
Dental Claims	United Healthcare Dental Attn: Claims Unit PO Box 30567 Salt Lake City, UT 84130-0567
Requests for Review of Denied Dental Claims	United Healthcare Dental Attn: Appeals PO Box 30569 Salt Lake City, UT 84130-0569
Vision Claims	United Healthcare Vision (Spectera) Claims Department PO Box 30978 Salt Lake City, UT 84130
Requests for Review of Denied Vision Claims	United Healthcare Vision (Spectera) Attn: Appeals 5959 Northwest Pkwy San Antonio, TX 78249
Life Insurance & Accidental Death and Dismemberment Claims	AFL-CIO Health & Welfare Plan– Fire Fighters 333 West Vine St., Suite 500 Lexington, KY 40507
Requests for Review of Denied Life Insurance & Accidental Death and Dismemberment Claims	AFL-CIO Health & Welfare Plan -- Fire Fighters 333 West Vine St., Suite 500 Lexington, KY 40507

SECTION 2: Key Terms

The meaning of some of the terms used most frequently throughout this booklet is explained below:

Benefit

A Benefit is one of the benefits offered by the Plan. The benefits for which you are or may become eligible are listed in the Employer Participation Summary section of this booklet.

Claims Administrator

The Claims Administrator is the entity responsible for claims processing and payment.

Dependent

Dependents are the Participant's legal spouse or unmarried child.

All references to the spouse of a Participant shall include a same-sex spouse and a Domestic Partner (as defined on page 7), except that a same-sex spouse or Domestic Partner is not eligible for COBRA continuation coverage or conversion coverage, and a Domestic Partner will be considered an acquired Dependent for purposes of enrollment outside the Initial Enrollment Period or any annual enrollment period only if the Participant provides a dated domestic partner registration.

The term child includes any of the following individuals:

- A natural child.
- A stepchild or foster child, if such child is primarily dependent upon the Participant for support and maintenance.
- A legally adopted child.
- A child placed in the Participant's home for adoption.
- A child for whom legal guardianship has been awarded to the Participant or the Participant's spouse.
- A minor grandchild, niece, or nephew under the primary care of the Participant. For purposes of this provision, "primary care" means that the Participant provides food, clothing, and shelter, on a regular and continuous

basis, for the minor grandchild, niece, or nephew during the time that public schools in their area are in regular sessions.

- A child of a same-sex spouse or a Domestic Partner who would qualify as a Dependent if the same-sex spouse or Domestic Partner were a Participant, so long as the same-sex spouse or Domestic Partner is also enrolled for benefits under the Plan except that a child who is covered as a child of a same-sex spouse or Domestic Partner is not eligible for COBRA continuation coverage or conversion coverage.

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

- A Dependent includes any unmarried child through December 31 of the calendar year in which he or she reaches age 19.
- A Dependent includes an unmarried child after the calendar year in which he or she reaches age 19, through the calendar year in which he or she reaches age 25 only if you furnish evidence upon our request, satisfactory to us, of all the following conditions:
  - The child must not be regularly employed on a full-time basis.
  - The child must be a Full-time Student.
  - The child must be dependent upon the Participant for support and maintenance.
- A Dependent includes a disabled child after dependent coverage would otherwise terminate if the child became incapable of self-sustaining employment solely because of mental or physical incapacity before dependent coverage would otherwise have terminated and written evidence of the incapacity was sent to the Plan (or, prior to August 1, 2007, to the Participant's employer) by January 31 following the end of the year in which coverage would otherwise have terminated. Such disabled child must remain incapable of self-sustaining employment and be primarily dependent upon the Participant for support and maintenance. Proof of continued incapacity may be requested by the Plan no more frequently than annually.

The Participant must reimburse the Plan for any Benefits that are paid for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order ("QMSCO") or other court or administrative order. The Plan is responsible for determining if an order meets the criteria of a QMCSO. A copy of the Plan's QMCSO procedures is available upon request from the Plan Office.

Note: if a child, same-sex spouse or Domestic Partner is enrolled in coverage from the Plan as your Dependent but you do not claim that individual as a dependent on your federal income tax return, the value of coverage provided to him or her may be taxable to you. Contact the Plan Office for details.

Domestic Partner

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

Domestic Partnership

A Domestic Partnership is a relationship between a Participant and one other person of the opposite or same sex, other than a legal marriage under the law of the state in which they reside. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage under the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must have shared the same household on a continuous basis for at least 6 months.
- They must be at least 18 years of age.
- They must be mentally competent to consent to contract.
- They must have registered as Domestic Partners where such registration is available and have not been registered as a member of another Domestic Partnership within the last six months.
- They must be financially interdependent and they have furnished documents to support at least two of the following conditions of such financial interdependence:
  - Joint ownership of real property or a common leasehold interest in such property for at least 6 months.
  - Joint ownership of an automobile.
  - Joint credit, checking, bank or investment account.
  - Will and/or life insurance policies which designates the other as primary beneficiary.

- Assignment of a durable power of attorney or health care power of attorney.
- Such other proof as is sufficient to establish economic interdependency under the circumstances of the particular case.

The Participant and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.

Eligible Person

An Eligible Person is an employee or retiree of the Employer who meets the eligibility requirements specified in this booklet and the Employer Participation Summary.

Employer

The Employer is the International Association of Fire Fighters.

Employer Participation Summary

The Employer Participation Summary is the chart in this booklet that lists the Benefits offered to eligible employees and retirees of your Employer or former Employer, and any other special rules applicable to employees and retirees of your Employer or former Employer that are not reflected in this booklet.

ERISA

ERISA is the Employee Retirement Income Security Act of 1974, as amended, a federal law that governs the operation of the Plan.

Full-Time Student

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

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

Full-time Student status is determined in accordance with the standards set forth by the educational institution. A Dependent is no longer a Full-time Student at the end of the calendar year during which he or she graduates or otherwise ceases to be enrolled and in attendance at the institution on a full-time basis.

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

Group Insurance Policy

The Group Insurance Policy is the insurance policy that your Employer has purchased from an insurance company to pay a particular Benefit. If a benefit booklet describing a particular Benefit refers to the Group Insurance Policy for that Benefit and you would like to review that Group Insurance Policy, please contact the Plan Office.

Initial Enrollment Period

The Initial Enrollment Period is the first period of time when Eligible Persons can enroll. The Initial Enrollment Period for an employee hired after August 1, 2007 is the 31-day period beginning on the date the employee becomes an Eligible Person (generally on the date of hire).

Participant

A Participant is an Employee who has met the requirements to be eligible for benefits from the Plan, and has not lost eligibility for those benefits.

Plan

The Plan is the AFL-CIO Health & Welfare Plan – Fire Fighters, which is a written document describing the operation of the Plan.

Plan Administrator

The Plan Administrator is the Employer. The Employer has delegated the day-to-day administrative duties to persons who work in the Plan Office.

Plan Office

The Plan Office is the AFL-CIO Health & Welfare Plan Office, 333 West Vine St., Suite 500, Lexington, KY 40507. The Employer has delegated the day-to-day administrative duties to persons who work in the Plan Office.

Qualifying event

A qualifying event is an event that entitles you to elect COBRA continuation health coverage from the Plan.

You

The terms “you” and “your” generally refer to Participants. In the section entitled Eligibility for Benefits, “you” and “your” include both Participants and Employees who are not yet Participants. In the section entitled Claims and Review Procedures the term “you” means all persons with a claim or potential claim for benefits. Also, in the following Benefit section(s) the terms “you” and “your” include both Participants and Dependents.

SECTION 3: Eligibility for Benefits

How do I become eligible for benefits from the Plan?

Eligible Persons are employees of the Employer that meet the eligibility requirements described in the Employer Participation Summary section of this booklet.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

An Eligible Person becomes a Participant eligible for benefits from the Plan on the first day of the month coincident with or next following the date on which he or she becomes an Eligible Person (generally the date of hire) by completing an enrollment form during his or her Initial Enrollment Period. After the end of the Initial Enrollment Period, an Eligible Person becomes a Participant eligible for benefits from the Plan by completing an enrollment form within the 31-day period beginning on:

1. The first day of any annual enrollment period as determined by the Plan, in which case coverage would be effective the first day of the month following any annual enrollment period;
2. The date on which the Eligible Person acquires a Dependent, in which case coverage would be effective on the date the Eligible Person acquired a Dependent;
3. The date on which the Eligible Person loses coverage, including exhaustion of COBRA coverage, under another group health plan, in which case coverage would be effective on the day after the last day of such other coverage, or
4. The date on which employer contributions under another group health plan covering the Eligible Person terminate, in which case coverage would be effective on the day after the last day of such other coverage.

Loss of coverage described under items 3 and 4 above do not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan).

Effective April 1, 2009, you and your Dependents may also enroll in this Plan if you (or your Dependents):

- Have coverage through Medicaid or a state children's Health Insurance Program (CHIP) and you (or your Dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.
- Become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your Dependents) are determined to be eligible for such assistance.

Participation will begin only after Contributions are accepted by the Plan on behalf of the Eligible Person. In no event may the effective date of participation of an Eligible Person precede the month for which Contributions are first accepted by the Plan. For enrollment based on acquiring a new Dependent child, coverage will begin on the date of birth, adoption or placement for adoption; and for enrollment based on a new Dependent spouse, not later than the first day of the month following receipt of a complete application for enrollment.

**Note: Coverage for Life Insurance and Accidental Death and Dismemberment benefits begins thirty (30) days after the date of your employment with your Employer.*

How do my spouse and other Dependents become eligible for benefits from the Plan?

Your Dependents (including your spouse) will become eligible for benefits on the day that you become a Participant (so long as the required contributions are made to the Plan on their behalf). This booklet may contain additional eligibility requirements for a particular benefit, such as completing an enrollment form, so you should read this booklet carefully.

In order for an otherwise eligible Domestic Partner to qualify for coverage under this Plan the Participant and Domestic Partner must jointly sign and submit the required affidavit of Domestic Partnership, along with a completed enrollment form and any other documentation required.

If you choose not to enroll your Dependents on the earliest possible date, any Dependent may become eligible for benefits:

- The first day of any annual enrollment period as determined by the Plan, in which case coverage would be effective the first day of the month following any annual enrollment period;
- If your Dependent was covered under another plan at the time they had an opportunity to be enrolled during the Initial Enrollment Period or any annual enrollment period:
    1. The date on which your Dependent loses coverage under the prior plan due to divorce, legal separation or death, in which case coverage would be effective on the day after the last day of such other coverage; or
    2. The date on which your Dependent loses coverage under the prior plan because the employer stopped paying contributions to that plan, in which case coverage would be effective on the day after the last day of such other coverage.

Effective April 1, 2009, your Dependents may also enroll in this Plan if they:

- Have coverage through Medicaid or a state children's Health Insurance Program (CHIP) and lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.
- Become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after your Dependents are determined to be eligible for such assistance.

**Note: Only you are eligible for coverage under the Life Insurance and Accident Death and Dismemberment benefits.*

How do I lose eligibility for benefits? How do my spouse and other Dependents lose their eligibility for benefits?

After the first occurrence of any of the following events, a Participant shall cease to be a Participant as of the end of the last month for which Contributions accepted by the Plan make the Participant eligible for participation as described below. Additionally, a Participant shall cease to be a Participant if (1) the Plan fails to receive the Contributions that are required to be made on behalf of the Participant, except that one or more insured Benefits may be continued to the extent provided in the applicable Certificate of Coverage, or (2) the Plan terminates.

Active employees:

- Active coverage for the Participants and Dependents will terminate on the latest of:
    1. The last day of the month in which active employment ceases (e.g., month in which retirement, termination, layoff, death, or disability occurs);
    2. The last day of the month in which the employee is on paid leave, unless the employee returns to active employment during that month;
    3. The last day of the month in which the employee is on unpaid leave for which the Employer is required by law to continue to provide health coverage; or
    4. For Dependents only, on the last day of the month in which the Dependent no longer meets the definition of Dependent, if the employee is still a Participant.

Retirees:

- Coverage for the Participant and Dependents will continue so long as the premium continues to be paid by the Employer and will be terminated if the Employer fails to submit 100% of the required payment for the retiree to the Plan when due, and the retiree may not later be re-enrolled. Coverage will be suspended if the Participant returns to work and qualifies for coverage from the Plan as an active employee.
- If the retiree dies, surviving spouse coverage will continue so long as the premium continues to be paid, but will be terminated at the end of the month in which re-marriage occurs or a new domestic partnership is established.
- Coverage for non-surviving spouse Dependents of retirees will terminate when surviving spouse coverage terminates or, if earlier, on the last day of the month in which the Dependent no longer meets the definition of Dependent.

A Participant whose participation terminates due to loss of employment, as described above, may elect to continue to receive medical coverage under the Plan either: (i) by electing COBRA continuation coverage and self-paying for coverage in accordance with procedures established by the Plan Administrator; or, (ii) if the Participant is eligible under the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"), by electing USERRA continuation coverage in accordance with procedures established by the Plan Administrator.

In addition, if any individual commits fraud or misrepresentation, or knowingly gives false material information, or permits an unauthorized person to use his or her ID card, or uses the ID card of another individual, the Plan reserves the right to terminate such individual's coverage, which may be retroactive.

Once a Participant has ceased to be a Participant, Benefits will cease to be paid for any claims incurred following termination of participation, except as otherwise provided in the applicable Certificate of Coverage.

How do payroll deductions affect my coverage?

If your Employer requires you to contribute toward your coverage through payroll deductions and you make a change in coverage or enrollment for yourself or your Dependents, you may need to change the amount you have authorized your Employer to deduct from your pay. If you do not do so, your Employer may not make the appropriate contributions to the Plan on behalf of you and/or your Dependents, resulting in termination of your benefits. Check with your Employer for details.

What if I go on leave for family or medical reasons?

The Family and Medical Leave Act (FMLA) is a federal law that permits eligible Employees to take up to twelve (12) weeks or twenty-six (26) weeks of unpaid, job-protected leave each year from their Employer for certain specified reasons. If you qualify, you may take FMLA leave for any of the following reasons:

- the birth of your child and to care for that child;
- the placement of a child with you for adoption or foster care;
- to care for your spouse, child or parent with a serious health condition;
- a serious health condition that makes you unable to perform your job; or
- effective January 28, 2008, to care for a covered serviceperson who is your spouse, child, parent or next of kin (i.e., nearest blood relative). In this circumstance, you are entitled to a total of 26 weeks of leave during a 12-month period to care for the serviceperson. In addition, you may be entitled to FMLA leave for a "qualifying exigency" arising out of the fact that your spouse, child, or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation. Contact your Employer for details.

During your FMLA leave, your Employer must provide you with the same health benefits that you were receiving immediately before your leave. This means that your Employer must continue to make the same contributions to the Plan on your behalf during your FMLA leave that it was making while you were at work.

Contact your Employer for further information and instructions on how to apply for FMLA leave.

What if I terminate employment and my new Employer's plan does not cover pre-existing conditions?

The Plan does not limit medical coverage for pre-existing conditions, but some plans do. Most plans are required to reduce this limit if you had prior coverage. For this reason, when you lose eligibility for medical benefits, the Plan is required to provide you with a Certificate of Coverage showing the amount of time that you were continuously covered by the Plan. If you are eligible for and elect COBRA coverage as described elsewhere in this booklet, you will receive another Certificate of Coverage after your COBRA coverage expires. You may also request a Certificate of Coverage at any time while you are still covered by the Plan or during the twenty-four (24) months after you lose your eligibility for medical benefits.

What if I have military service?

A Participant who enters military service shall be provided continuation and reinstatement rights in accordance with the USERRA. This section contains important information about your rights to continuation coverage and reinstatement rights under USERRA.

What is USERRA Continuation Coverage?

USERRA continuation coverage is a continuation of Plan coverage when it would otherwise end because you have been called to active duty in the uniformed services. USERRA protects employees who leave for and return from any type of uniformed service in the United States armed forces, including the Coast Guard, the reserves of any of the armed forces, the National Guard or the Public Health Service.

Your Plan coverage will terminate when you enter active duty in the uniformed services. If you elect USERRA continuation coverage, you, your spouse, and your dependent children may continue Plan coverage for 24 months from the date you ceased working in covered employment due to your call to active duty.

How do I elect USERRA continuation coverage?

The Plan will offer you USERRA continuation coverage only after the Plan Office has been notified that you have been called to active duty in the uniformed services. When you are called to active duty, you must notify the Plan Office as soon as possible, but in no event later than 60 days after the date on which you would lose coverage due to your call to active duty. Notice will be excused if it was impossible or unreasonable to give notice to the Plan Office under the circumstances, or if notice was precluded by military necessity as defined by USERRA.

How is USERRA provided?

Once the Plan Office receives notice of your call to active duty, you will be offered the right to elect USERRA continuation coverage. You may elect USERRA for yourself or for yourself plus your spouse and dependent children. Unlike COBRA, if you do not elect USERRA for yourself, your spouse and dependent children cannot elect it separately.

In order to be eligible for USERRA continuation coverage, you must follow the same election procedures as for COBRA, and must elect the coverage on a timely basis. Failure to elect USERRA on a timely basis means that USERRA rights are forfeited.

You may also be eligible for continuation coverage under COBRA when you enter military service. COBRA continuation coverage and USERRA continuation coverage run simultaneously, not consecutively.

How do I pay for USERRA Continuation Coverage?

If your military service is for less than 30 days, coverage for you and your covered dependents will be continued under the Plan, as long as you pay any required employee contributions due for coverage during that time period.

If you are on active duty for more than 31 days, USERRA permits you to continue medical and dental coverage for you, your spouse and your dependents at your own expense for up to 24 months. This continuation right operates in the same way as COBRA. See below for a full explanation of the COBRA coverage provision, which will allow you to continue your medical and dental coverage.

What happens after my Discharge?

You must also notify the Plan Office in writing within the time period required under USERRA after your discharge. When you are discharged (not less than honorably) from military service, your full eligibility will be reinstated on the day you return to work with your Employer, provided that you return to employment within:

- ninety (90) days from the date of discharge if the period of service was more than one hundred eighty (180) days; or
- fourteen (14) days from the date of discharge if the period of service was thirty-one (31) days or more but less than one hundred eighty (180) days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than thirty-one (31) days.

If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

What if I have more questions about USERRA continuation coverage?

If you have any questions about taking a leave, please speak directly with your Employer. If you have any questions about how a leave or absence affects your benefits, please contact the Plan Office. Your USERRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

SECTION 4: Continuation Coverage Under Federal Law (COBRA)

Extended Coverage

How can I continue coverage once I am no longer eligible for benefits?

Once you are no longer eligible for medical benefits, you may be able to continue coverage in two ways: by electing COBRA coverage as described below or, if your benefits are insured by a company that provides conversion rights, by purchasing an individual insurance policy.

What is COBRA coverage?

COBRA continuation coverage is a continuation of medical coverage available to you and your covered Dependents when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed below.

Individuals who elect COBRA continuation coverage must pay for COBRA continuation coverage. The administration of COBRA coverage is the responsibility of the Plan Office.

In order to protect your family's rights, it is important to keep the Plan Office informed of the current addresses of all of your family members who are or could become eligible for COBRA coverage. You should also keep a copy, for your records, of any notices you send to the Plan Office.

Which of my family members are eligible for COBRA coverage?

Each of your Dependents who is covered by the Plan when a qualifying event as defined below occurs is eligible for COBRA coverage unless he or she is entitled to Medicare. In addition, if a child is born to or adopted by you while your COBRA coverage is in effect or if you acquire a new spouse, that child or spouse is eligible for COBRA coverage. You and each of your Dependents eligible for COBRA coverage is referred to as a "qualified beneficiary", except that individuals covered as a Domestic Partner, same-sex spouse or a child of a Domestic Partner or same-sex spouse cannot be a "qualified beneficiary."

What events are qualifying events that make me and my Dependents eligible for COBRA coverage?

You and your eligible Dependents will each become a qualified beneficiary and may elect COBRA coverage when a qualifying event occurs. A qualifying event may be different for you and your eligible Dependents.

Qualifying Events for You

The following events are qualifying events for you if they result in a loss of medical benefits, unless you are entitled to Medicare:

- reduction in your hours of employment or termination of your employment (for reasons other than for gross misconduct); or
- if you are a retiree, your former Employer's commencing federal bankruptcy proceedings under Title 11 of the U.S. Code.

Qualifying Events for Your Dependents

The following are qualifying events for your Dependents if they result in a loss of medical benefits:

- your death;
- reduction in your hours of employment or termination of your employment (for reasons other than gross misconduct);
- your divorce or legal separation;
- if you are a retiree, your former Employer's commencing federal bankruptcy proceedings under Title 11 of the U.S. Code;
- your becoming enrolled in Medicare (Part A, Part B, or both); or
- for a child, ceasing to qualify as a Dependent.

Plan Termination

If you or one of your Dependents has a qualifying event, and your Employer terminates the Plan, you and your Dependents may again be eligible for COBRA coverage when your Employer makes group health coverage available to (or starts contributing to a multiemployer plan with respect to) a class of employees formerly covered under the Plan, at which point the other plan will be required to assume the COBRA obligation with respect to you and your Dependents.

If a qualifying event occurs, how do my Dependents and I get COBRA coverage?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Office has been notified that a qualifying event has occurred. When the qualifying event is termination of employment or reduction in your hours of employment, your death, commencement of a proceeding in bankruptcy with respect to the Employer, or your enrollment in Medicare (Part A, Part B or both), the Employer must notify the Plan of the qualifying event within thirty (30) days of the qualifying event.

For the other qualifying events (your divorce or legal separation, or your child losing eligibility for coverage as a Dependent), you or your Dependent(s) must notify the Plan Office within sixty (60) days of the qualifying event.

Once the Plan Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

Is there a special rule if I am eligible for Trade Adjustment Assistance benefits?

Each qualified beneficiary is entitled to a second COBRA election period if: (a) you are certified by the Department of Labor as eligible for trade act assistance (TAA) benefits under the Trade Act of 1974 on or after November 4, 2002; (b) the qualified beneficiary lost coverage under the Plan due to your job loss that resulted in eligibility for TAA benefits; and (c) the qualified beneficiary did not elect COBRA coverage during the initial election period resulting from that job loss. Specifically, each qualified beneficiary has another opportunity to elect COBRA during the sixty (60) day period that begins on the first day of the month in which you were certified, and the election must also be made within six months after the date Plan coverage is lost. You or your Dependent(s) are responsible for notifying the Plan Office of your TAA eligibility and providing a copy of the certification. Accordingly, if you are eligible for TAA benefits, you or your Dependent(s) must contact the Plan Office immediately after you become certified or all qualified beneficiaries will lose the special COBRA rights. If a qualified beneficiary elects COBRA coverage under this provision, it will begin on the first day of the sixty (60) day election period and will last the same length of time as if an election had been made based on the original qualifying event.

How long will my COBRA coverage last?

COBRA continuation coverage is a temporary continuation of coverage. Unless there is an early cut-off as described below, COBRA continuation coverage lasts for up to eighteen (18) months if the qualifying event is the termination of or reduction in hours of your employment, or up to thirty-six (36) months if the qualifying event is your death, your divorce or legal separation, your enrollment in Medicare (Part A, Part B or both), or a child losing eligibility as a Dependent. There are two ways in which this eighteen (18) month period of COBRA continuation coverage can be extended.

Disability Extension of Eighteen (18) Month Period of Continuation Coverage

If you or any covered Dependent are determined by the Social Security Administration to be disabled at any time during the first sixty (60) days of COBRA continuation coverage and you notify the Plan Office in a timely fashion, you and each of your covered Dependents can receive up to an additional eleven (11) months of COBRA coverage, for a total maximum of twenty-nine (29) months. You must make sure that the Plan Office is notified of the Social Security Administration's determination within sixty (60) days of the date of the determination and before the end of the eighteen (18) month period of COBRA continuation coverage.

Second Qualifying Event Extension of Eighteen (18) Month Period of Continuation Coverage

If you or a covered Dependent has another qualifying event while receiving COBRA continuation coverage, your covered Dependents can get additional months of COBRA continuation coverage, up to a maximum of thirty-six (36) months. This extension is available to your spouse and dependent children if you die, enroll in Medicare (Part A, Part B or both), or get divorced or legally separated. The extension is also available to a child when that child stops being eligible under the Plan as a Dependent. In all of these cases, you must make sure that the Plan Office is notified of the second qualifying event within sixty (60) days of the second qualifying event and within the initial eighteen (18) months of continuation coverage.

What will cause an early cut-off of COBRA coverage?

COBRA coverage will automatically end as of the date any of the following cut-off events occurs:

- the covered individual does not pay the premium for COBRA coverage on time;
- the covered individual becomes covered under any other group health plan that does not limit coverage for his or her pre-existing conditions;
- the covered individual becomes entitled to Medicare;
- your Employer terminates the Plan and makes other group health coverage available to (or starts contributing to another plan with respect to) a class of employees formerly covered under the Plan; or
- for a covered individual who is receiving COBRA coverage based on a determination of disability, the first day of the month immediately following the month in which there is a final determination by the Social Security Administration that the individual is no longer disabled.

The covered individual is required to notify the Plan Office of any of the above cut-off events and the Plan may terminate COBRA coverage retroactively to the date of the cut-off event.

How can I get additional information about COBRA?

If you have questions about your COBRA continuation rights and coverage, you should contact the Plan Office or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

What if a court orders the Plan to cover my children?

The Plan will comply with the terms of any judgment, decree or order that creates or recognizes the right of one or more of your children to receive medical benefits, so long as that judgment, decree or order is a QMCSO under Section 609 of ERISA. Coverage under such an order will not extend the maximum period of COBRA coverage. A description of the procedures governing QMCSOs may be obtained, without charge, from the Plan Office.

What is conversion coverage?

Conversion coverage enables you to have an individual medical benefit policy with the insurer. If your coverage terminates for one of the reasons described below, you may apply for conversion coverage without furnishing evidence of insurability, except that an individual covered as a Domestic Partner, same-sex spouse or a child of a Domestic Partner is not eligible for conversion coverage.

Reasons for termination:

- The Participant is retired or pensioned.
- You cease to be eligible as a Participant or Enrolled Dependent.
- Continuation coverage ends.
- The entire Policy ends and is not replaced.

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

SECTION 5: How to File a Claim

Instructions for filing a claim differ by type of benefit. See the applicable attachment (Attachments A through E) for claim filing instructions.

SECTION 6: United Healthcare's Claims and Appeals Notice

(This Notice applies to your medical, prescription, dental and vision benefits. This notice does not apply to the Life Insurance or Accidental Death and Dismemberment Benefits. The claims and appeal procedures for the Life Insurance and Accidental Death and Dismemberment benefits are described in Attachment E.)

This Notice is provided to you as a result of changes in federal law regarding United Healthcare's responsibilities for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you.

Benefit Determinations

Post-Service Claims

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

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

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

If you have prescription drug benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe

that it should have been paid under the policy, you may submit a claim for reimbursement in accordance with the applicable claim filing procedures. If you pay a copayment and believe that the amount of the copayment was incorrect, you also may submit a claim for reimbursement in accordance with the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Pre-Service Claims

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

Urgent Claims that Require Immediate Attention

Urgent claims are those claims that require notification or a benefit determination prior to receiving medical or dental 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 United Healthcare receives all necessary information, taking into account the seriousness of your condition.

- Notice of denial may be oral with a written or electronic confirmation to follow within three days.

If you filed an urgent claim improperly, United Healthcare will notify you of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, United Healthcare 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 benefit determination no later than 48 hours after:

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

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

Concurrent Care Claims

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

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

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally contact United Healthcare’s customer service department before requesting a formal appeal. If the customer service representative cannot resolve

the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a customer service representative. If you first informally contact United Healthcare's customer service department and later wish to request a formal appeal in writing, you should again contact customer service and request an appeal. If you request a formal appeal, a customer service representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to the *Urgent Claim Appeals that Require Immediate Action* section below and contact United Healthcare's customer service department immediately.

How to Appeal a Claim Decision

If you disagree with a claim determination after following the above steps, you can contact United Healthcare in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

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

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

Appeal Process

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

Appeals Determinations

Pre-service and Post-service Claim Appeals

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

- For appeals of **pre-service claims** as identified above, the first level appeal will be conducted and you will be notified 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 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** as identified above, the first level appeal will be conducted and you will be notified 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 of the decision within 30 days from receipt of a request for review of the first level appeal decision.

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

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

Please note that United Healthcare's decision is based only on whether or not benefits are available under the policy for the proposed treatment or procedure. United Healthcare does not determine whether the pending medical or dental service is necessary or appropriate. That decision is between you and your medical or dental provider.

Urgent Claim Appeals that Require Immediate Action

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

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

SECTION 7: Limits on Benefits

COORDINATION OF BENEFITS

Most group health care plans, including this Plan, contain a *coordination of benefits* ("COB") provision. This provision is used when you or your Dependents have health care coverage under more than one group health plan. The object of coordination of benefits is to assure you that your covered expenses will be paid, while preventing duplicate benefit payments. Coordination of benefits prevents duplication and works to the advantage of all members of the Plan.

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

1. "Coverage Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.

    a. "Coverage Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.

    b. "Coverage Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

    Each contract for coverage under a. or b. above is a separate Coverage Plan. If a Coverage Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Coverage Plan.

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

    When this Coverage Plan is primary, its benefits are determined before those of any other Coverage Plan and without considering any other

Coverage Plan's benefits. When this Coverage Plan is secondary, its benefits are determined after those of another Coverage Plan and may be reduced because of the Primary Coverage Plan's benefits.

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

    a. If a Covered Person is confined in a private Hospital room, the difference between the cost of a Semi-private Room in the Hospital and the private room, (unless the patient's stay in a private Hospital room is medically necessary in terms of generally accepted medical practice, or one of the Coverage Plans routinely provides coverage for Hospital private rooms) is not an Allowable Expense.

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

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

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

    e. The amount a benefit is reduced by the Primary Coverage Plan because a Covered Person does not comply with the Coverage

Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

4. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.
5. "Closed Panel Plan" is a Coverage Plan that provides health benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
6. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules:

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

1. The Primary Coverage Plan pays or provides its benefits as if the Secondary Coverage Plan or Coverage Plans did not exist.
2. A Coverage Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide out-of-network benefits.
3. A Coverage Plan may consider the benefits paid or provided by another Coverage Plan in determining its benefits only when it is secondary to that other Coverage Plan.
4. The first of the following rules that describes which Coverage Plan pays its benefits before another Coverage Plan is the rule to use.

a. Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a dependent, for example as an employee or retiree is primary and the Coverage Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage Plan covering the person as a dependent; and primary to the Coverage Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as an employee, member or retiree is secondary and the other Coverage Plan is primary.

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

1) The Primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:

a) The parents are married;

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

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

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

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

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

a) The Coverage Plan of the custodial parent;

b) The Coverage Plan of the spouse of the custodial parent;

c) The Coverage Plan of the noncustodial parent; and then

d) The Coverage Plan of the spouse of the noncustodial parent.

c. Active or inactive employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary, unless the employee meets the exception described below. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled D(1).

The Coverage Plan is not primary if the employee is over the age 65, is employed by an employer with fewer than twenty (20) employees, and has been notified by the Plan that Medicare is primary for the employee.

d. Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage Plan covering the person as an employee or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored.

e. Longer or shorter length of coverage. The Coverage Plan that covered the person as an employee or retiree longer is primary.

f. If a husband or wife is covered under this Coverage Plan as both an employee (or retiree) and as an Enrolled Dependent, the dependent benefits will be coordinated as if they were provided under another Coverage Plan, this means the employee's (or retiree's) benefit will pay first.

g. If the preceding rules do not determine the Primary Coverage Plan, the Allowable Expenses shall be shared equally between

the Coverage Plans meeting the definition of Coverage Plan under this provision. In addition, this Coverage Plan will not pay more than it would have paid had it been primary.

Effect on the Benefits of this Plan

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

   a. Determine its obligation to pay or provide benefits under its contract;

   b. Determine whether a benefit reserve has been recorded for the Covered Person; and

   c. Determine whether there are any unpaid Allowable Expenses during that claims determination period.

   If there is a benefit reserve, the Secondary Coverage Plan will use the Covered Person's benefit reserve to pay up to 100 percent of total Allowable Expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

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

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

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

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

How Benefits May Be Reduced, Delayed or Lost

There are certain situations under which Benefits may be reduced, delayed or lost. Most of these circumstances are spelled out in this booklet, but Benefit payments also may be affected if you, your beneficiary or your provider of services, as applicable, do not:

- file a claim for Benefits properly or on time
- furnish the information required to complete or verify a claim
- have a current address on file with the Plan Office
- permit a United Healthcare Network Physician to examine you in the event of a question or dispute regarding your right to Benefits

You should also be aware that Benefits are not payable for enrolled dependents who become ineligible due to age, marriage, divorce or legal separation (unless they elect and pay for COBRA benefits, as described in Section 12).

If the Plan mistakenly pays more than you are eligible for, or pays for Benefits that were not authorized by the Plan, the Plan may seek any permissible remedy allowed by law to recover benefits paid in error (also see the next Section, “Subrogation, Reimbursement of Expenses, and Overpayments.”

Subrogation, Reimbursement of Expenses, and Overpayments

This section briefly describes the Plan's subrogation provisions. Please refer to the Certificate of Coverage, which is available from the Plan Administrator, for a complete description of the subrogation provisions.

Subrogation

If United Healthcare makes payment for a Benefit on account of sickness or accidental bodily injury, and you recover monies from another source on account of or in connection with that sickness or accidental bodily injury, you are responsible for reimbursing United Healthcare any monies paid by another source up to the amount paid by United Healthcare. If legal action is instituted against any such other source, United Healthcare is entitled to intervene and participate in that action. If you do not institute legal action, United Healthcare may do so in your name. If you are injured through an act or omission of another party (for example, a car accident) or where another person is otherwise responsible for your sickness or accidental bodily injury, benefits under this Plan will be provided in connection with that sickness or accidental bodily injury only if you agree in writing to:

- Reimburse United Healthcare (to the extent of benefits provided) immediately upon receipt of any payment from any other source on account of or in connection with such sickness or accidental bodily injury; and
- Authorize the insurance carrier for the responsible party (or the uninsured motorist or no-fault insurance carrier) to make payment to United Healthcare to the extent of benefits provided; and
- Provide United Healthcare with a lien against any monies recovered as described in paragraph 1 above; and
- Authorize United Healthcare to intervene in any suit or other proceedings against a responsible party as described above, and/or to institute such legal action in your name in the circumstances described above.

Reimbursement of Expenses

If United Healthcare pays benefits for expenses incurred on account of you or your Dependents, you or any other person or organization that was paid must make a refund to United Healthcare if all or some of the expenses were recovered from or paid by a source other than United Heathcare's insurance policies as a result of claims against a third party for negligence, wrongful acts or omissions.

The refund equals the amount of the recovery or payment, up to the amount that United Healthcare paid.

If the refund is due from another person or organization, you or your Dependents agree to help United Healthcare get the refund when requested.

If you, or any other person or organization that was paid, does not promptly refund the full amount, United Healthcare may reduce the amount of any future benefits that are payable to you. The reduction will equal the amount of the required refund. United Healthcare may have other rights in addition to the right to reduce future benefits.

The foregoing provisions shall also apply to your Dependents with respect to benefits provided to them.

Overpayments

If you (or your Dependent) are overpaid for a claim, you must return the overpayment. The Plan will have the right to recover any payments made that were based on false or fraudulent information, as well as any payments made in error. Amounts recovered may include interest and costs. If repayment is not made, the Plan may deduct the overpayment amount from any future Benefits from this Plan that you and your beneficiary would otherwise receive.

If payment is made on your (or a Dependent's) behalf to a hospital, doctor or other provider of health care and that payment is found to be an overpayment, the Plan will request a refund of the overpayment from the provider. If the refund is not received, the amount of the overpayment will be deducted from future Benefits payable to the provider, or a lawsuit may be initiated to recover the overpayment.

Limitation of Legal Action

You cannot bring any legal action against United Healthcare to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in the applicable section of Attachments A through D. If you want to bring a legal action against United Healthcare, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against United Healthcare.

You cannot bring any legal action against United Healthcare for any other reason unless you first complete all the steps in the complaint process described in below. After completing that process, if you want to bring a legal action against United Healthcare, you must do so within three years of the date that United Healthcare notified you of its final decision on your complaint or you lose any rights to bring such an action against United Healthcare.

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

What to Do First

Contact United Healthcare's Customer Service Department.

The telephone number is shown on your insurance ID card.

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

What to Do Next

If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. United Healthcare will notify you of its decision regarding your complaint within 31 days of receiving it.

What to Do if You Disagree with United Healthcare's Decision

If you disagree with United Healthcare's decision after following the above steps, you can ask United Healthcare in writing to formally reconsider your complaint.

If the complaint relates to a claim for payment, your request should include:

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

United Healthcare will appoint a committee to resolve or recommend the resolution of the complaint. If your complaint is related to clinical matters, the committee will include health care professionals who did not make the first determination. United Healthcare may consult with, or seek the participation of, medical experts as part of the complaint resolution process.

The committee will meet to resolve your complaint within 60 days of receiving your request. The committee will review testimony, explanations or other information that it decides is necessary for a fair review of the complaint.

United Healthcare will send you written notification of the committee's decision within 14 days of the review. If you are still not satisfied with our decision, you have the right to take your complaint to the Office of the Commissioner of Insurance.

Please note that United Healthcare's decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. United Healthcare does not determine whether the pending health service is necessary or appropriate. That decision is between you and your Physician.

What to Do if Your Complaint Requires Immediate Action

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

- The appeal does not need to be submitted in writing. You or your Physician should call United Healthcare as soon as possible.
- United Healthcare will notify you of the decision by the end of the next business day after your appeal is received, unless more information is needed.
- If United Healthcare needs more information from your Physician to make a decision, United Healthcare will notify you of the decision by the end of the next business day following receipt of the required information.

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

If you are not satisfied with United Healthcare's decision, you have the right to take your complaint to the Office of the Commissioner of Insurance.

Voluntary External Review Program

If United Healthcare makes a final determination to deny Benefits, you may choose to participate in its voluntary external review program. This program only applies if United Healthcare's decision is based on either of the following:

- Clinical reasons.
- The exclusion for Experimental, Investigational or Unproven Services. The external review program is not available if United Healthcare's coverage determinations are based on Benefit exclusions or defined Benefit limits.

Contact United Healthcare at the telephone number shown on your insurance ID card for more information on the voluntary external review program.

SECTION 8: Plan Privacy Policy

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Plan's Commitment to Privacy

The Plan is committed to protecting the privacy of the information it maintains that identifies you and relates to your physical or mental health, or to the provision or payment of health services for you ("health information"). In accordance with applicable law, you have certain rights, as described in this Notice, related to your health information.

This Notice informs you of the Plan's legal obligations under the federal health privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the related regulations ("federal health privacy law"):

- to maintain the privacy of your health information;
- to provide you with this Notice describing the Plan's legal duties and privacy practices with respect to your health information; and
- to follow the terms of this Notice.

This Notice also informs you how the Plan uses and discloses your health information and explains the rights that you have with regard to your health information maintained by the Plan. For purposes of this Notice, "you" or "your" refer to Participants and Dependents who are eligible for benefits under the Plan.

Information Subject to This Notice

The Plan collects and maintains certain health information about you to help provide health benefits to you, as well as to fulfill legal and regulatory requirements. The Plan obtains this health information from applications and other forms that you complete, through conversations you may have with the Plan's administrative staff, and from reports and data provided to the Plan by health care service providers. This is the information that is subject to the privacy practices described in this Notice. The health information the Plan has about you includes, among other things, your name, address, phone number, birthdate, social security number, employment information, and medical and health claims information.

Summary of the Plan's Privacy Practices

The Plan's Uses and Disclosures of Your Health Information

The Plan uses your health information to determine your eligibility for benefits, to process and pay your health benefits claims, and to administer its operations. The Plan discloses your health information to insurers, third party administrators, and health care providers for treatment, payment and health care operations purposes. The Plan may also disclose your health information to third parties that assist the Plan in its operations, to government and law enforcement agencies, to your family members, and to certain other persons or entities. In certain circumstances, the Plan will only use or disclose your health information pursuant to your written authorization. In other cases authorization is not needed. The details of the Plan's uses and disclosures of your health information are described below.

Your Rights Related to Your Health Information

The federal health privacy law provides you with certain rights related to your health information. Specifically, you have the right to:

- inspect and/or copy your health information;
- request that your health information be amended;
- request an accounting of certain disclosures of your health information;
- request certain restrictions related to the use and disclosure of your health information;
- request to receive your health information through confidential communications; and
- file a complaint with the Plan or the Secretary of the Department of Health and Human Services if you believe that your that privacy rights have been violated.

These rights and how you may exercise them are detailed below.

Changes in the Plan's Privacy Practices

The Plan reserves its right to change its privacy practices and revise this Notice as described below.

Contact Information

If you have any questions or concerns about the Plan's privacy practices, or about this Notice, or if you wish to obtain additional information about the Plan's privacy practices, please contact:

HIPAA Privacy Officer
AFL-CIO Health & Welfare Plan – Fire Fighters
333 West Vine St., Suite 500
Lexington, KY 40507
Phone: 859-226-1719
Fax: 859-226-1726

DETAILED NOTICE OF THE PLAN'S PRIVACY POLICIES

The Plan's Uses and Disclosures

Except as described in this section, as provided for by federal privacy law, or as you have otherwise authorized, the Plan uses and discloses your health information only for the administration of the Plan and the processing of your health claims.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

1. **For Treatment.** While the Plan does not anticipate making disclosures "for treatment," if necessary, the Plan may make such disclosures without your authorization. For example, the Plan may disclose your health information to a health care provider, such as a hospital or physician, to assist the provider in treating you.
2. **For Payment.** The Plan may use and disclose your health information so that claims for health care treatment, services and supplies that you receive from health care providers can be paid according to the Plan's terms. For example, the Plan may share your enrollment, eligibility, and claims information with a third party administrator so that it may process your claims. If you appeal a denial of benefits, the Plan may disclose your health information to the Plan Administrator so that the Plan Administrator may decide the appeal. The Plan may also disclose your health information to health care providers to notify them whether certain medical treatment or other health benefits are covered under the Plan, and to claims auditors to review billing practices of health care providers and to verify the appropriateness of claims payment.
3. **For Health Care Operations**. The Plan may use and disclose your health information to enable it to operate efficiently and in the best interest of its participants. For example, the Plan may disclose your health information to actuaries and accountants for business planning purposes, or to attorneys who are providing legal services to the Plan.

Uses and Disclosures to Business Associates

The Plan shares health information about you with its "business associates," which are third parties that assist the Plan in its operations. The Plan discloses information, without your authorization, to its business associates for treatment, payment and health care operations. For example, the Plan shares your health information with a third party administrator so that it may process your claims.

The Plan may disclose your health information to auditors, actuaries, accountants, and attorneys as described above.

The Plan enters into agreements with its business associates to ensure that the privacy of your health information is protected.

Uses and Disclosures to the Plan Sponsor

The Plan may disclose your health information to the Plan Sponsor, for plan administration purposes, such as performing quality assurance functions and evaluating overall funding of the Plan, without your authorization. The Plan also may disclose your health information to the Plan Sponsor for purposes of hearing and deciding your claims appeals. Before any health information is disclosed to the Plan Sponsor, the Plan Sponsor will certify to the Plan that it will protect your health information and that it has amended the Plan's plan documents to reflect its obligation to protect the privacy of your health information.

Other Uses and Disclosures That May Be Made Without Your Authorization

As described below, the federal health privacy law provides for specific uses or disclosures that the Plan may make without your authorization:

1. **Required by Law**. Your health information may be used or disclosed as required by law. For example, your health information may be disclosed for judicial and administrative proceedings pursuant to court or administrative order legal process and authority; to report information related to victims of abuse, neglect, or domestic violence; and to assist law enforcement officials in their law enforcement duties.
2. **Health and Safety.** Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person. Your health information also may be disclosed for public health activities, such as preventing or controlling disease, injury or disability, and to meet the reporting and tracking requirements of governmental agencies, such as the Food and Drug Administration.
3. **Government Functions.** Your health information may be disclosed to the government for specialized government functions, such as intelligence, national security activities, security clearance activities and protection of public officials. Your health information also may be disclosed to health oversight agencies for audits, investigations, licensure and other oversight activities.

4. **Active Members of the Military and Veterans**. Your health information may be used or disclosed in order to comply with laws and regulations related to military service or veterans' affairs.
5. **Workers' Compensation.** Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation benefits.
6. **Emergency Situations**. Your health information may be used or disclosed to a family member or close personal friend involved in your care in the event of an emergency or to a disaster relief entity in the event of a disaster.
7. **Others Involved In Your Care**. In limited circumstances, your health information may be used or disclosed to a family member, close personal friend, or others who the Plan has verified are directly involved in your care (for example, if you are seriously injured and unable to discuss your case with the Plan). Also, upon request, the Plan may advise a family member or close personal friend about your general condition, location (such as in the hospital) or death. If you do not want this information to be shared, you may request that these disclosures be restricted as outlined later in this Notice.
8. **Personal Representatives**. Your health information may be disclosed to people that you have authorized to act on your behalf, or people who have a legal right to act on your behalf. Examples of personal representatives are parents of unemancipated minors and those who have Power of Attorney.
9. **Treatment and Health-Related Benefits Information**. The Plan and its business associates may contact you to provide information about treatment alternatives or other health-related benefits and services that may interest you, including, for example, alternative treatment, services and medication.
10. **Research**. In certain circumstances, your health information may be used or disclosed for research purposes as long as the procedures required by law to protect the privacy of the research data are followed.
11. **Organ, Eye and Tissue Donation**. If you are an organ donor, your health information may be used or disclosed to an organ donor or procurement organization to facilitate an organ or tissue donation or transplantation.
12. **Deceased Individuals**. The health information of a deceased individual may be disclosed to coroners, medical examiners, and funeral directors so that those professionals can perform their duties.

Uses and Disclosures for Fundraising and Marketing Purposes

The Plan and its business associates do not use your health information for fundraising or marketing purposes.

Any Other Uses and Disclosures Require Your Express Authorization

Uses and disclosures of your health information ***other than*** those described above will be made only with your express written authorization. You may revoke your authorization to use or disclose your health information in writing. If you do so, the Plan will not use or disclose your health information as authorized by the revoked authorization, except to the extent that the Plan already has relied on your authorization. Once your health information has been disclosed pursuant to your authorization, the federal privacy law protections may no longer apply to the disclosed health information, and that information may be re-disclosed by the recipient without your knowledge or authorization.

Your Health Information Rights

You have the following rights regarding your health information that the Plan creates, collects and maintains.

Right to Inspect and Copy Health Information

You have the right to inspect and obtain a copy of your health record. Your health record includes, among other things, health information about your plan eligibility, plan coverages, claim records, and billing records.

To inspect and copy your health record, submit a written request to the HIPAA Privacy Officer. The Plan may deny your request in certain very limited circumstances. In some of these circumstances, you may have the denial reviewed.

Right to Request That Your Health Information Be Amended

You have the right to request that your health information be amended if you believe the information is incorrect or incomplete.

To request an amendment, submit a detailed written request to the HIPAA Privacy Officer. This request must provide the reason(s) that support your request. The Plan may deny your request if it is not in writing, it does not provide a reason in support of the request, or if you have asked to amend information that:

- was not created by or for the Plan, unless you provide the Plan with information that the
- person or entity that created the information is no longer available to make the amendment;
- is not part of the health information maintained by or for the Plan;
- is not part of the health record information that you would be permitted to inspect and copy; or
- is accurate and complete.

The Plan will notify you in writing as to whether it accepts or denies your request for an amendment to your health information. If the Plan denies your request, it will explain how you can continue to pursue the denied amendment.

Right to an Accounting of Disclosures

You have the right to receive a written accounting of disclosures. The accounting is a list of disclosures of your health information by the Plan to others, except that disclosures for treatment, payment or health care operations, disclosures made to or authorized by you, and certain other disclosures are not part of the accounting. The accounting covers up to six years prior to the date of your request (but will not include disclosures made before April 14, 2003). If you want an accounting that covers a time period of fewer than six years, please state that in your written request for an accounting.

To request an accounting of disclosures, submit a written request to the HIPAA Privacy Officer. The first accounting that you request within a twelve month period will be free. For additional accountings in a twelve month period, you will be charged for the cost of providing the accounting, but the Plan will notify you of the cost involved before processing the accounting so that you can decide whether to withdraw your request before any costs are incurred.

Right to Request Restrictions

You have the right to request restrictions on your health care information that the Plan uses or discloses about you to carry out treatment, payment or health care operations, or to someone who is involved in your care or the payment for your care, such as a family member or friend. The Plan is not required to agree to your request for such restrictions, and the Plan may terminate any agreement it has made to the restrictions you requested.

To request restrictions, submit a written request to the HIPAA Privacy Officer that explains what information you seek to limit, and how and/or to whom you would like the limit(s) to apply. The Plan will notify you in writing as to whether it agrees to your request for restrictions, and when it terminates agreement to any restriction.

Right to Request Confidential Communications, or Communications by Alternative Means or at an Alternative Location

You have the right to request that your health information be communicated to you in confidence by alternative means or to an alternative location. For example, you can ask that you be contacted only at work or by mail, or that you be provided with access to your health information at a specific location.

To request communications by alternative means or at an alternative location, submit a written request to the HIPAA Privacy Officer. Your written request should state the reason for your request, and the alternative means by or location at which you would like to receive your health information. If appropriate, your request should state that the disclosure of all or part of the information by non-confidential communications could endanger you. Reasonable requests will be accommodated to the extent possible and you will be notified appropriately.

Right to Complain

You have the right to complain to the Plan and to the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with the Plan, submit a written complaint to the HIPAA Privacy Officer listed above. You will not be penalized in any way for filing a complaint.

Changes in the Plan's Privacy Policies

The Plan reserves the right to change its privacy practices and make the new practices effective for all health information that it created or received before the effective date of the change and that it may receive in the future.

The Genetic Information Nondiscrimination Act

This Plan will comply with the Genetic Information Nondiscrimination Act (GINA) when it becomes effective, and will not use genetic information for prohibited purposes, including underwriting.

Effective Date

This Notice is effective as of July 1, 2007, and will remain in effect unless and until the Plan publishes a revised Notice.

SECTION 9: Statement of ERISA Rights

As a Participant, you have certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). These include the right to:

- Examine, without charge, all Plan documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. You may look at these documents at the Plan Office or other locations such as union halls and worksites where at least fifty (50) participants work;
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan may make a reasonable charge for the copies;
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to provide each participant with a copy of the summary annual report every year; and
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation rights.

In addition to creating rights for Plan Participants, ERISA requires the people who operate the Plan to meet certain responsibilities. These people, called "fiduciaries," must act solely in the interest of you and other Participants and beneficiaries, and must act prudently in performing their duties.

Although the Plan does not guarantee your employment, no one may fire you or discriminate against you to prevent you from obtaining a benefit or exercising your rights under ERISA (not your Employer, the union or any other person).

If your claim for a benefit is denied, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights:

- If you ask the Plan Administrator for a copy of plan documents or the latest annual report from the plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you a fine of up to $110 a day until you receive them, unless the materials were not sent because of reasons beyond the Plan's control.
- If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or Federal court.
- If you disagree with the Plan Administrator's (or its delegate's) decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.
- If Plan fiduciaries ever misuse the Plan's money or you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay the court costs and legal fees – possibly the person you have sued if your case is successful. However, if you lose the case, the court may order you to pay court costs and legal fees – if the court finds your claim is frivolous, for example.

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

SECTION 10: Statement of Rights Under The Newborns' and Mothers' Health Protection Act

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

SECTION 11: Women's Health and Cancer Rights Act of 1998

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

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

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

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

SECTION 12: HIPAA Notice

Changes Required By Final HIPAA Regulations

Changes required by the final HIPAA Portability Regulations are effective July 1, 2005. Those changes include clarification of the requirements for a Special Enrollment Period and Continuous Creditable Coverage as described below.

Special Enrollment Period

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

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

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

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.

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

- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or any applicable Open Enrollment Period; and
- Coverage under the prior plan ended because of any of the following:
  - Loss of eligibility (including, without limitation, legal separation, divorce or death).

- The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
- In the case of COBRA continuation coverage, the coverage ended.
- The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.
- The plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
- An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.

Continuous Creditable Coverage

Continuous Creditable Coverage is defined as health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- A group health plan.
- Health insurance coverage.
- Medicare.
- Medicaid.
- Medical and dental care for members and certain former members of the uniformed services, and for their dependents.
- A medical care program of the Indian Health Services Program or a tribal organization.
- A state health benefits risk pool.
- The Federal Employees Health Benefits Program.
- The State Children's Health Insurance Program (S-CHIP).
- Health plans established and maintained by foreign governments or political subdivisions and by the U.S. government.
- Any public health benefit program provided by a state, county, or other political subdivision of a state.
- A health benefit plan under the Peace Corps Act.

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.

Maximum Policy Benefit

The terms of your Certificate of Coverage may define and establish terms relating to a Maximum Policy Benefit. This maximum policy benefit may impose a preexisting condition limitation under the updated HIPAA Portability regulations.

SECTION 13: Plan Information

This section provides you with legal information about the Plan.

Name of Plan

AFL-CIO Health & Welfare Plan – Fire Fighters

Name, Address and Telephone Number of Plan Sponsor

The International Association of Fire Fighters. All communications to the Plan Sponsor should be sent to:

AFL-CIO Health & Welfare Plan -- Fire Fighters
333 West Vine St., Suite 500
Lexington, KY 40507
Phone: 859-226-1719
Fax: 859-226-1726

Employer Identification Number (EIN)

53-0088290

Plan Number

501

Type of Plan

Health care coverage and life insurance plan.

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

The Plan Sponsor is the Plan Administrator. All communications to the Plan Administrator should be sent to:

AFL-CIO Health & Welfare Plan – Fire Fighters
333 West Vine St., Suite 500
Lexington, KY 40507
Phone: 859-226-1719
Fax: 859-226-1726

Claims Administrator/Third Party Administrator

Companies that provide certain administrative services for the Plan:

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

UMR (Lexington Kentucky)
333 West Vine St., Suite 500
Lexington, KY 40507
Phone: 859-226-1719
Fax: 859-226-1726

The Union Labor Life Insurance Company (ULLICO)
8403 Colesville Road
Silver Spring, MD 20910

United Healthcare, UMR, and ULLICO shall not be deemed or construed as an employer under the Plan for any purpose with respect to the administration or provision of Benefits under the AFL-CIO Health & Welfare Plan – Fire Fighters. United Healthcare shall not be responsible for fulfilling any duties or obligations of an employer with respect to the AFL-CIO Health & Welfare Plan – Fire Fighters.

Type of Administration of the Plan

The Plan Sponsor provides certain administrative services in connection with the Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a network provider, claims processing services, including coordination of benefits and subrogation, utilization management, and complaint resolution assistance. This external administrator is referred to as the Claims Administrator.

Benefits are paid pursuant to the terms of group health Policies issued and insured by United Healthcare Insurance Company and pursuant to the terms of group life insurance Policies issued and insured by ULLICO.

Person designated as agent for service of legal process

Plan Administrator
AFL-CIO Health & Welfare Plan – Fire Fighters
333 West Vine St., Suite 500
Lexington, KY 40507
Phone: 859-226-1719

Method of calculating the amount of Contribution

Participant-required Contributions to the Plan are the Participant's share of costs as determined by the Employer.

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

Plan year shall be a twelve-month period ending July 31.

Determinations of Qualified Medical Child Support Orders

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

Claims Procedures

The Plan's claims procedures are described in each benefit section attached.

Plan Document

Benefits under the Plan are furnished in accordance with the Certificates of Coverage issued by the United Healthcare and ULLICO. Copies of the documents may be obtained by Participants and Dependents upon written request to the Plan Administrator and are available within 30 calendar days after written request is received and directed to the Plan Administrator.

In the event there is a discrepancy between the Plan Information of this Summary Plan Description and that of the Certificates of Coverage, the actual provisions of the Certificates of Coverage shall prevail.

SECTION 14: Your Health and Welfare Benefits

ATTACHMENT A:

Medical Benefits

SECTION 1: Key Terms

This Section:
• Defines the terms used throughout this Attachment. • Is not intended to describe Benefits.

Alternate Facility

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

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

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

Annual Deductible

The amount you must pay for Covered Health Services in a calendar year before United Healthcare will begin paying for Non-Network Benefits in that calendar year.

Congenital Anomaly

A physical developmental defect that is present at birth, and is identified within the first twelve months of birth.

Copayment

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

Cosmetic Procedures

Procedures or services that change or improve appearance without significantly improving physiological function, as determined by United Healthcare.

Covered Health Service(s)

Those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or their symptoms.

A Covered Health Service is a health care service or supply described in (Section 2: What's Covered—Benefits) as a Covered Health Service, which is not excluded under (Section 3: What's Not Covered—Exclusions).

Covered Person

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

Custodial Care

Services that:

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

Designated Facility

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

Durable Medical Equipment

Medical equipment that is all of the following:

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

Eligible Expenses

The amounts United Healthcare will pay for Covered Health Services, incurred while the Policy is in effect, and are determined as stated below:

- For Network Benefits, Eligible Expenses are based on either of the following:
  - When Covered Health Services are received from Network providers, Eligible Expenses are our contracted fee(s) with that provider.
  - When Covered Health Services are received from non-Network providers as a result of an Emergency or as otherwise arranged by United Healthcare, Eligible Expenses are the fee(s) that United Healthcare negotiates with the non-Network provider.
- For Non-Network Benefits, Eligible Expenses are based on either of the following:
  - When Covered Health Services are received from non-Network providers, United Healthcare calculates Eligible Expenses based on available data resources of competitive fees in that geographic area.
  - When Covered Health Services are received from Network providers, Eligible Expenses are our contracted fee(s) with that provider.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. United Healthcare develops its reimbursement policy guidelines, in its discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association.

- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that United HealthCare accepts.

Emergency

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

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

Emergency Health Services

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

Experimental or Investigational Services

Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time United Healthcare makes a determination regarding coverage in a particular case, are determined to be any of the following:

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

If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment) United Healthcare 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, United Healthcare 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.

Home Health Agency

A program or organization authorized by law to provide health care services in the home.

Hospital

An institution, operated as required by law, that is both of the following:

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

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

Initial Enrollment Period

The initial period of time, as United Healthcare agrees with the AFL-CIO Health & Welfare Plan – Fire Fighters, during which Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury

Bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility

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

Inpatient Stay

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

Maximum Policy Benefit

The maximum amount that United Healthcare will pay for Benefits during the entire period of time that you are enrolled under the Policy issued to your Employer. The Maximum Policy Benefit includes any amount that United Healthcare has paid for Benefits under a former Policy issued to the Employer that is replaced by the current Policy, as well as any amount that United Healthcare may pay under a later Policy that replaces the current Policy. When the Maximum Policy Benefit applies, it is described in (Section 2: What's Covered—Benefits).

Medicare

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

Mental Health Services

Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Morbid Obesity

(1) a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables, (2) a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes, or (3) a BMI of 40 kilograms per meter squared without comorbidity. "Body Mass Index (BMI)" equals body weight in kilograms divided by height in meters squared.

Mental Health/Substance Abuse Designee

The organization or individual, designated by United Healthcare, that provides or arranges Mental Health Services and Substance Abuse Services for which Benefits are available under the Policy.

Mental Illness

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

Network

When used to describe a provider of health care services, this means a provider that has a participation agreement in effect with United Healthcare or with its affiliate (directly or through one or more other organizations) to provide Covered Health Services to Covered Persons.

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

Network Benefits

Benefits for Covered Health Services that are provided by (or directed by) a Network Physician or other Network provider in the provider's office or at a Network facility.

Non-Network Benefits

Benefits for Covered Health Services that are provided by or directed by a non-Network Physician at a non-Network facility.

Open Enrollment Period

A period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. United Healthcare and the AFL-CIO Health & Welfare Plan – Fire Fighters will agree upon the period of time that is the Open Enrollment Period.

Out-of-Pocket Maximum

The maximum amount of Annual Deductible and Copayments you pay every calendar year. Once you reach the Out-of-Pocket Maximum for Non-Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that calendar year.

Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum, as specified in (Section 2: What's Covered—Benefits).

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

- Any charges for non-Covered Health Services;
- Copayments for Covered Health Services available by an optional Rider.
- The amount of any reduced Benefits if you don't notify United Healthcare as described in (Section 2: What's Covered—Benefits) under the *Must You Notify United Healthcare?* column.
- Charges that exceed Eligible Expenses.
- Any Copayments for Covered Health Services in Section 2: What's Covered—Benefits) that do not apply to the Out-of-Pocket Maximum.

Physician

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

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

Plan

The AFL-CIO Health & Welfare Plan – Fire Fighters, consisting of the detailed rules and regulations setting forth the terms and conditions of benefits payable to the Participants.

Policy

The entire agreement issued to the Employer, that includes all of the following:

- The group Policy.
- This Certificate of Coverage.
- The Employer's application.
- Amendments.
- Riders.

These documents make up the entire agreement that is issued to the Employer.

Policy Charge

The sum of the Premiums for all Participants and Enrolled Dependents enrolled under the Policy.

Pregnancy

Includes all of the following:

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

Premium

The periodic fee required for each Participant and each Enrolled Dependent, in accordance with the terms of the Policy.

Rider

Any attached written description of additional Covered Health Services not described in this Attachment. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by United Healthcare and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room

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

Sickness

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

Skilled Nursing Facility

A Hospital or nursing facility that is licensed and operated as required by law.

Spinal Treatment

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

Substance Abuse Services

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

Unproven Services

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

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

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

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) United Healthcare may, in its discretion, determine that an Unproven Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, United Healthcare must determine that the procedure or treatment is promising, but

unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by *the National Institutes of Health.*

Urgent Care Center

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

SECTION 2: What's Covered—Benefits

This section provides you with information about:
• Accessing Benefits. • Copayments and Eligible Expenses. • Annual Deductible, Out-of-Pocket Maximum and Maximum Policy Benefit. • Covered Health Services. United Healthcare pays Benefits for the Covered Health Services described in this section unless they are listed as not covered in (Section 3: What's Not Covered—Exclusions). • Covered Health Services that require you or your provider to notify United Healthcare before you receive them. In general, Network providers are responsible for notifying United Healthcare before they provide certain health services to you. You are responsible for notifying United Healthcare before you receive certain health services from a non-Network provider.

Accessing Benefits

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

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under a United Healthcare Choice Plus Policy. As a result, they may bill you for the entire cost of the services you receive. For details about when Network Benefits apply, see (Section 4: Description of Network and Non-Network Benefits).

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

- Covered Health Services are received while the group Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed on pages 13 and 14 occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

Copayment

Copayment is the amount you pay each time you receive certain Covered Health Services. For a complete definition of Copayment, see (Section 1: Key Terms). Copayment amounts are listed on the following pages next to the description for each Covered Health Service. Please note that when Copayments are calculated as a percentage (rather than as a set dollar amount) the percentage is based on Eligible Expenses.

Eligible Expenses

Eligible Expenses are the amount United Healthcare determines that it will pay for Benefits. For a complete definition of Eligible Expenses that describes how United Healthcare determines payment, see (Section 1: Key Terms). For Network Benefits, you are not responsible for any difference between the Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount United Healthcare will pay for Eligible Expenses.

Notification Requirements

United Healthcare requires notification before you receive certain Covered Health Services. In general, Network providers are responsible for notifying United Healthcare before they provide these services to you. There are some Network Benefits, however, for which you are responsible for notifying United Healthcare.

When you choose to receive certain health services from non-Network providers, you are responsible for notifying United Healthcare before you receive these services.

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

To notify United Healthcare, call the telephone number on your ID card for Customer Service.

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

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

Note Regarding Medicare

If you are enrolled for Medicare on a primary basis (Medicare pays before United Healthcare pays Benefits under the Policy), the notification requirements described in this SPD do not apply to you. Since Medicare is the primary payer, United Healthcare will pay as secondary payer. You are not required to notify United Healthcare before receiving Covered Health Services.

Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services before you are eligible to receive Non-Network Benefits. For a complete definition of Annual Deductible, see (Section 1: Key Terms).	*Network* No Annual Deductible. *Non-Network* $50 per Covered Person per calendar year, not to exceed $150 for all Covered Persons in a family.
Out-of-Pocket Maximum	The maximum you pay, out of your pocket, in a calendar year for Copayments. For a complete definition of Out-of-Pocket Maximum, see (Section 1: Key Terms).	*Network* No Out-of-Pocket Maximum. *Non-Network* $1,050 per Covered Person per calendar year, not to exceed $3,150 for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible.
Maximum Policy Benefit	The maximum amount United Healthcare will pay for Non-Network Benefits during the entire period of time you are enrolled under the Policy. For a complete definition of Maximum Policy Benefit, see (Section 1: Key Terms).	*Network* No Maximum Policy Benefit. *Non-Network* $2,000,000 per Covered Person.

Benefit Information

Description of Covered Health Service	Must You Notify United Healthcare?	Your Copayment Amount Copayments are based on a percent of Eligible Expenses. (*See definition of Eligible Expenses on page 79*)	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
1. Acupuncture Services Acupuncture services for pain therapy when both of the following are true: • Another method of pain management has failed. • The service is performed by a provider in the provider's office.	Network No	No Copayment	No	No
	Non-Network No	20%	Yes	Yes
2. Ambulance Services—Emergency only Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.	Network No	*Ground Transportation:* No Copayment *Air Transportation:* 0%	No	No
	Non-Network No	Same as Network	Same as Network	Same as Network
3. Dental Services—Accident only Dental services when all of the following are true: • Treatment is necessary because of accidental damage. • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D." • The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was: • A virgin or unrestored tooth, or • A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech. Dental services for final treatment to repair the damage must be both of the following: • Started within three months of the accident. • Completed within 12 months of the accident. Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities.	Network Yes	No Copayment	No	No
	Non-Network Yes	Same as Network	Same as Network	Same as Network

Description of Covered Health Service	Must You Notify United Healthcare?	Your Copayment Amount Copayments are based on a percent of Eligible Expenses. (*See definition of Eligible Expenses on page 79*)	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• *Notify United Healthcare* Please remember that you must notify United Healthcare as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. (You do not have to notify United Healthcare before the initial Emergency treatment.) If you don't notify United Healthcare, Benefits will be reduced to 50% of Eligible Expenses.				
4. Dependent Child Health Services Benefits from the moment of birth to age 21 including: 1. *Coverage for injury or sickness*, including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, and prematurity; and	<u>Network</u> No	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Rehabilitation Services-Outpatient Therapy.		
	<u>Non-Network</u> Yes for Hospital Inpatient Stays	20%. No Copay for wellness visits	Yes	Yes, except for wellness visits
2. *Coverage for preventive and primary care services*, including physical examinations, measurements, sensory screening, neuropsychiatric evaluation, and development screening, which coverage shall include unlimited visits for children up to the age of 12 years, and 3 visits per year for minor children ages 12 years up to 21 years of age. Preventive and primary care services shall also include, as recommended by the physician, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including tests to screen for sickle hemoglobinopathy. 3. *Child Health Screenings and Immunizations* Screening tests and immunizations as required by the Uniform Child Health Screenings and Reporting Form Act of 2004. Coverage includes but is not limited to, the tests and immunizations listed in the District of Columbia Child Health Certificate. *Notify United Healthcare* Please remember that for Hospital Inpatient Stays (Network and Non-Network Benefits) you must notify United Healthcare five business days before receiving services. If you don't notify United Healthcare, Benefits will be reduced to 50% of Eligible Expenses.				
5. Diabetes Treatment Coverage for diabetic equipment, diabetes supplies and in-person outpatient diabetic self-management training and education programs (including medical nutrition therapy) when provided under the direction of a Physician by a certified, registered or licensed health care professional.	<u>Network</u> No	Same as Physician's Office Services, Professional Fees, and Outpatient Diagnostic and Therapeutic Services.		
	<u>Non-Network</u> Yes	20%	Yes	Yes
Diabetes self-management training includes training provided to a Covered Person after the initial diagnosis in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies. Coverage is also provided for additional training upon diagnosis of a significant change in medical condition that requires a change in the self-management regime, and periodic continuing education training as warranted by the development of new techniques and treatment for diabetes. *Notify United Healthcare* Please remember that for Non-Network Benefits you must notify United Healthcare five business days before receiving services. If you don't notify United Healthcare, Benefits will be reduced to 50% of Eligible Expenses.				

Description of Covered Health Service	Must You Notify United Healthcare?	Your Copayment Amount Copayments are based on a percent of Eligible Expenses. (*See definition of Eligible Expenses on page 79*)	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
6. Durable Medical Equipment Durable Medical Equipment that meets each of the following criteria: • Ordered or provided by a Physician for outpatient use. • Used for medical purposes. • Not consumable or disposable. • Not of use to a person in the absence of a disease or disability. • If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment. Examples of Durable Medical Equipment include: • Urological Supply • Equipment to assist mobility, such as a standard wheelchair. • A standard Hospital-type bed. • Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks). • Delivery pumps for tube feedings (including tubing and connectors). • Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are excluded from coverage. • Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage). United Healthcare will decide if the equipment should be purchased or rented. To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor United Healthcare identifies. Any combination of Network and Non-Network Benefits for Durable Medical Equipment is limited to $100,000 per calendar year. This limit applies to the total amount that United Healthcare will pay for the Durable Medical Equipment, and does not include any Copayment or Annual Deductible responsibility you may have. Notify United Healthcare Please remember that for Non-Network Benefits you must notify United Healthcare before obtaining any single item of Durable Medical Equipment that costs more than $1,000 (either purchase price or cumulative rental of a single item). If you don't notify United Healthcare, Benefits will be reduced to 50% of Eligible Expenses.	Network No	No Copayment	No	No
	Non-Network Yes, for items more than $1,000	20%	Yes	Yes
7. Emergency Health Services Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility. You will find more information about Benefits for Emergency Health Services In (Section 4: Description of Network and Non-Network Benefits).	Network No	No Copayment	No	No
	Non-Network Yes, but only for an Inpatient Stay	Same as Network	Same as Network	Same as Network

Description of Covered Health Service	Must You Notify United Healthcare?	Your Copayment Amount Copayments are based on a percent of Eligible Expenses. (*See definition of Eligible Expenses on page 79*)	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Please remember that if you are admitted to a non-Network Hospital as a result of an Emergency, you must notify United Healthcare within one business day or the same day of admission, or as soon as reasonably possible. If you don't notify United Healthcare, Benefits for the non-Network Hospital Inpatient Stay will be reduced to 50% of Eligible Expenses. Benefits will not be reduced for the outpatient Emergency Health Services.				
8. Habilitative Services Except for Habilitative Services provided in early intervention and school services, Habilitative Services for children 0—21 years old. "Habilitative Services" means services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function. For purposes of Habilitative Services, a congenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. A congenital or genetic birth defect includes, but is not limited to (a) autism or autism spectrum disorder, and (b) cerebral palsy. Please note: Services for Rehabilitative Services (not described here) are covered under the section titled Rehabilitation Services – Outpatient Therapy.	<u>Network</u> No	$5 per visit	No	No
	<u>Non-Network</u> No	20%	Yes	Yes
9. Hair Prosthesis For loss of natural hair resulting from chemotherapy or radiation treatment for cancer when prescribed by the resident oncologist.	<u>Network</u> No	0%	No	No
	<u>Non-Network</u> No	20%	Yes	Yes
10. Hearing Aids Hearing aids which are required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver. Hearing aids are limited to the purchase of two hearing aids every two calendar years. Any combination of Network and Non-Network Benefits for hearing aids is limited to $500 every two years.	<u>Network</u> No	0%	No	No
	<u>Non-Network</u> No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify United Healthcare?	Your Copayment Amount Copayments are based on a percent of Eligible Expenses. (*See definition of Eligible Expenses on page 79*)	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
11. Home Health Care Services received from a Home Health Agency that are both of the following: • Ordered by a Physician. • Provided by or supervised by a registered nurse in your home.	Network No	No Copayment	No	No
	Non-Network Yes	20%	Yes	Yes

Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required.

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

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

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

Any combination of Network and Non-Network Benefits is limited to 40 visits per calendar year. One visit equals four hours of skilled care services.

Notify United Healthcare
Please remember that for Non-Network Benefits you must notify United Healthcare five business days before receiving services. If you don't notify United Healthcare, Benefits will be reduced to 50% of Eligible Expenses.

12. Hospice Care Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person,	Network No	No Copayment	No	No
	Non-Network Yes	20%	Yes	Yes

and short-term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed hospice agency.

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

Any combination of Network and Non-Network Benefits is limited to $5,000 during the entire period of time you are covered under the Policy.

Notify United Healthcare
Please remember that for Non-Network Benefits you must notify United Healthcare five business days before receiving services. If you don't notify United Healthcare, Benefits will be reduced to 50% of Eligible Expenses.

Description of Covered Health Service	Must You Notify United Healthcare?	Your Copayment Amount Copayments are based on a percent of Eligible Expenses. (*See definition of Eligible Expenses on page 79*)	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
13. Hospital—Inpatient Stay Inpatient Stay in a Hospital. Benefits are available for: • Supplies and non-Physician services received during the Inpatient Stay.	Network No	No Copayment	No	No
	Non-Network Yes	20%	Yes	Yes
• Room and board in a Semi-private Room (a room with two or more beds). • Coverage is provided for newborn infant hearing screenings and all necessary audiological examinations as recommended by the national Joint Committee on Infant Hearing. For the purposes of this coverage, "Hospital" shall include birthing centers or other centers having newborn nurseries. Notify United Healthcare Please remember that for Non-Network Benefits you must notify United Healthcare as follows: • For elective admissions: five business days before admission. • For non-elective admissions: within one business day or the same day of admission. • For Emergency admissions: within one business day or the same day of admission, or as soon as is reasonably possible. If you don't notify United Healthcare, Benefits will be reduced to 50% of Eligible Expenses.				
14. Injections received in a Physician's Office Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.	Network No	$5 per visit	No	No
	Non-Network No	20% per injection	Yes	Yes
15. Mammography Benefits for mammography testing that is consistent with the recommendations of governmental scientific agencies. Benefits for mammography testing are payable when mammography testing is performed as follows: 1. A baseline mammogram; and 2. Follow-up mammograms on an annual basis.	Network No	0%	No	No
	Non-Network No	0%	No	No

Description of Covered Health Service	Must You Notify United Healthcare?	Your Copayment Amount Copayments are based on a percent of Eligible Expenses. (*See definition of Eligible Expenses on page 79*)	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
16. Maternity Services Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. United Healthcare also has special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify United Healthcare during the first trimester, but no later than one month prior to the anticipated childbirth.	<u>Network</u>	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Diagnostic and Therapeutic Services.		
	No	No Copayment applies to Physician office visits for prenatal care after the first visit.		
	<u>Non-Network</u>			
	Yes if Inpatient Stay exceeds time frames.	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Diagnostic and Therapeutic Services.		

United Healthcare will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

In all cases of early discharge, United Healthcare shall provide coverage for post-delivery care within the minimum time periods shown above in the Participant's home, or, in a provider's office, as determined by the Physician in consultation with the mother.

The at-home post-delivery care shall be provided by a registered professional nurse, physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health, and shall include:

1. Parental education;
2. Assistance and training in breast or bottle feeding; and
3. Performance of any medically necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.

Notify United Healthcare
Please remember that for Non-Network Benefits you must notify United Healthcare as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described. If you don't notify United Healthcare that the Inpatient Stay will be extended, your Benefits for the extended stay will be reduced to 50% of Eligible Expenses.

Description of Covered Health Service	Must You Notify United Healthcare?	Your Copayment Amount Copayments are based on a percent of Eligible Expenses. (*See definition of Eligible Expenses on page 79*)	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
17. Medical Foods Coverage for medical foods and low protein modified food products when prescribed and administered under the direction of a Physician for the treatment of inherited metabolic diseases caused by an inherited abnormality of body chemistry.	Network No	0%	No	No
	Non-Network No	20%	Yes	Yes
"Low protein modified food product" means a food product that is: • Specially formulated to have less than one gram of protein per serving; and • Intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease. "Low protein modified food product" does not include a natural food that is naturally low in protein. "Medical food" means a food that is: • Intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and • Formulated to be consumed or administered enterally under the direction of a Physician.				
18. Mental Health and Substance Abuse Services—Outpatient Mental Health Services and Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including: • Mental health, substance abuse and chemical dependency evaluations and assessment. • Diagnosis. • Treatment planning. • Referral services. • Medication management. • Short-term individual, family and group therapeutic services (including intensive outpatient therapy). • Crisis intervention.	Network You must call the Mental Health/ Substance Abuse Designee to receive the Benefits.	*For Substance Abuse Services:* $10 per visit *For Mental Illness Services:* $10 per visit	No	No
	Non-Network You must call the Mental Health/ Substance Abuse Designee to receive the Benefits.	25% for the first 40 visits per calendar year. 40% for each additional visit per calendar year.	No	No
For Network Benefits, referrals to a Mental Health/Substance Abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Network Benefits for outpatient Mental Health and Substance Abuse Services. Any combination of Network and Non-Network Benefits for Mental Health Services and Substance Abuse Services are subject to no visit limitations. Authorization Required Please remember that you must call and get authorization to receive these Benefits in advance of any treatment through the Mental Health/Substance Abuse Designee. The Mental Health/Substance Abuse Designee phone number appears on your ID card. Without authorization, you will be responsible for paying all charges and no Benefits will be paid.				

Description of Covered Health Service	Must You Notify United Healthcare?	Your Copayment Amount Copayments are based on a percent of Eligible Expenses. (*See definition of Eligible Expenses on page 79*)	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
19. Mental Health and Substance Abuse Services—Inpatient and Intermediate Mental Health Services and Substance Abuse Services received on an inpatient or intermediate care basis in a Hospital or an Alternate Facility or a nonhospital residential facility. Benefits include detoxification from abusive chemicals or substances that is limited to physical detoxification when necessary to protect your physical health and well-being. The Mental Health/Substance Abuse Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. At the discretion of the Mental Health/Substance Abuse Designee, two sessions of intermediate care (such as partial hospitalization) may be substituted for one inpatient day. Network Benefits for Mental Health Services and Substance Abuse Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. For Network Benefits, referrals to a Mental Health/Substance Abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for inpatient/intermediate Mental Health Services and Substance Abuse Services. Intermediate care services for the purpose of detoxification are limited to 12 days per calendar year.	<u>Network</u> You must call the Mental Health/ Substance Abuse Designee to receive the Benefits.	No Copayment	No	No
	<u>Non-Network</u> You must call the Mental Health/ Substance Abuse Designee to receive the Benefits.	20%	Yes	Yes
20. Obesity Surgery Coverage for treatments of morbid obesity including gastric bypass surgery or other surgical methods as recognized by the will be reduced to 50% of Eligible Expenses. National Institutes of Health as effective for the long-term reversal of morbid obesity. Covered surgical procedures include, but are not limited to: Roux-en-Y gastric bypass (RGB), Gastric banding, and Vertical Banded Gastroplasty (VBG). The following procedures are not covered: procedures classified as intestinal bypass surgery including but not limited to Biliopancreatic diversions and Jejuno-ileal bypasses and including the reversal of such procedures. Surgical treatment of obesity when provided by or under the direction of a Physician when either of the following criteria is met: • The Covered Person must have a Body Mass Index (BMI) of greater than 40. • The Covered Person must have a Body Mass Index (BMI) of greater than 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by, obesity. Notify United Healthcare Please remember that for Non-Network Benefits you must notify United Healthcare five business days before receiving services. If you don't notify United Healthcare, Benefits	<u>Network</u> No	0%	No	No
	<u>Non-Network</u> Yes	20%	Yes	Yes

Description of Covered Health Service	Must You Notify United Healthcare?	Your Copayment Amount Copayments are based on a percent of Eligible Expenses. (*See definition of Eligible Expenses on page 79*)	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
21. Orthotics Orthotics that meets each of the following criteria: • Ordered or provided by a Physician for outpatient use. • Used for medical purposes. • Not consumable or disposable.	Network No	0%	No	No
	Non-Network Yes, if greater than $1,000	20%	Yes	Yes
• Not of use to a person in the absence of a disease or disability. If more than one piece of Orthotics can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment. United Healthcare will decide if the equipment should be purchased or rented. To receive Network Benefits, you must purchase or rent the Orthotic from the vendor United Healthcare identifies. Notify United Healthcare Please remember that for Non-Network Benefits you must notify United Healthcare before obtaining any single item of Orthotics that costs more than $1,000 (either purchase or cumulative rental of a single item). If you don't notify United Healthcare, you will be responsible for paying fifty percent of the Eligible Expenses.				
22. Ostomy Supplies Benefits for ostomy supplies include only the following: • Pouches, face plate and belts. • Irrigation sleeves, bags and catheters. • Skin barriers. Benefits are not available for gauze, adhesive, adhesive remover, deodorant, pouch covers, or other items not listed above.	Network No	0%	No	No
	Non-Network Yes, for items more than $1,000	20%	Yes	Yes

Description of Covered Health Service	Must You Notify United Healthcare?	Your Copayment Amount Copayments are based on a percent of Eligible Expenses. (*See definition of Eligible Expenses on page 79*)	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
23. Outpatient Surgery, Diagnostic and Therapeutic Services *Outpatient Surgery* Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.	Network No	No Copayment	No	No
	Non-Network Yes	0%	No	No
Benefits under this section include only the facility charge and the charge for required Hospital-based professional services, supplies and equipment. Benefits for the surgeons fees related to outpatient surgery are described under *Professional Fees for Surgical and Medical Services*. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.				
Outpatient Diagnostic Services Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including: • Lab and radiology/X-ray. • Mammography testing. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below. This section does not include Benefits for CT scans, Pet scans, MRIs, or nuclear medicine, which are described immediately below.	Network No	*For lab and radiology/X-ray:* No Copayment *For mammography testing:* No Copayment	No No	No No
	Non-Network No	20%	Yes	Yes
Outpatient Diagnostic/Therapeutic Services—CT Scans, Pet Scans, MRI and Nuclear Medicine Covered Health Services for CT scans, Pet scans, MRI, and nuclear medicine received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.	Network No	No Copayment	No	No
	Non-Network Yes	20%	Yes	Yes
Outpatient Therapeutic Treatments Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.	Network No	No Copayment	No	No
	Non-Network No	20%	Yes	Yes
Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.				

Description of Covered Health Service	Must You Notify United Healthcare?	Your Copayment Amount Copayments are based on a percent of Eligible Expenses. (*See definition of Eligible Expenses on page 79*)	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
24. Physician's Office Services *Covered Health Services for preventive medical care. Preventive medical care includes:* • Voluntary family planning. • Well-baby and well-child care. • Routine physical examinations.	Network No	No Copayment	No	No
	Non-Network No	No Copayment	No	No
• Vision and hearing screenings for children age 17 and under including follow-up audiological examinations for newborns as recommended by a Physician or Audiologist and performed by a licensed audiologist. • Pap smears (including an annual cytology screening and any such screening deemed medically necessary by the Physician). • Immunizations (including those considered routine and necessary for newborn children from birth to 36 months of age)				
Covered Health Services for the diagnosis and treatment of a Sickness or Injury.	Network No	$5 per visit No Copayment applies when no Physician charge is assessed.	No	No
	Non-Network No	20%	Yes	Yes
25. Private Duty Nursing Private Duty Nursing in residential homes is covered.	Network No	Same as Home Health Care		
	Non-Network Yes	Same as Home Health Care		
26. Professional Fees for Surgical and Medical Services Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.	Network No	No Copayment	No	No
	Non-Network No	No Copayment for Surgical services, 20% Copayment for all other services.	No	No

Description of Covered Health Service	Must You Notify United Healthcare?	Your Copayment Amount Copayments are based on a percent of Eligible Expenses. (*See definition of Eligible Expenses on page 79*)	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
27. Prosthetic Devices Prosthetic devices that replace a limb or body part including: • Artificial limbs. • Artificial eyes. • Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device. The prosthetic device must be ordered or provided by, or under the direction of a Physician. Any combination of Network and Non-Network Benefits for prosthetic devices is limited to $100,000 per calendar year.	Network No	No Copayment	No	No
	Non-Network Yes, if greater than $1,000	20%	Yes	Yes
28. Reconstructive Procedures Services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function. Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure. Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy related to breast cancer, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact United Healthcare at the telephone number on your ID card for more information about Benefits for mastectomy-related services. Notify United HealthCare Please remember that for Non-Network Benefits you must notify United Healthcare five business days before receiving services. When you notify United Healthcare, United Healthcare can verify that the service is a reconstructive procedure rather than a Cosmetic Procedure. Cosmetic Procedures are always excluded from coverage. If you don't notify United Healthcare, Benefits for reconstructive procedures will be reduced to 50% of Eligible Expenses.	Network No	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.		
	Non-Network Yes	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.		

Description of Covered Health Service	Must You Notify United Healthcare?	Your Copayment Amount Copayments are based on a percent of Eligible Expenses. (*See definition of Eligible Expenses on page 79*)	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
29. Rehabilitation Services—Outpatient Therapy Short-term outpatient rehabilitation services for: • Physical therapy. • Occupational therapy. • Speech therapy.	<u>Network</u> No	 $5 per visit	 No	 No
	<u>Non-Network</u> No	 20%	 Yes	 Yes
• Pulmonary rehabilitation therapy. • Cardiac rehabilitation therapy Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment. Please note that United Healthcare will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly.				
Any combination of Network and Non-Network Benefits is limited as follows: • 100 visits of physical therapy per calendar year. • 100 visits of occupational therapy per calendar year. • 100 visits of speech therapy per calendar year. • 100 visits of pulmonary rehabilitation therapy per calendar year. • 100 visits of cardiac rehabilitation therapy per calendar year.				
30. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay.	<u>Network</u> No	 No Copayment	 No	 No
	<u>Non-Network</u> Yes	 20%	 Yes	 Yes
• Room and board in a Semi-private Room (a room with two or more beds). • Any combination of Network and Non-Network Benefits is limited to 60 days per calendar year. Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital. Notify United Healthcare Please remember that for Non-Network Benefits you must notify United Healthcare as follows: • For elective admissions: five business days before admission. • For non-elective admission: within one business day or the same day of admission. • For Emergency admissions: within one business day or the same day of admission, or as soon as is reasonably possible. If you don't notify United Healthcare, Benefits will be reduced to 50% of Eligible Expenses.				

Description of Covered Health Service	Must You Notify United Healthcare?	Your Copayment Amount Copayments are based on a percent of Eligible Expenses. (*See definition of Eligible Expenses on page 79*)	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
31. Spinal Treatment Benefits for Spinal Treatment when provided by a Spinal Treatment provider in the provider's office. Benefits include diagnosis and related services and are limited to one visit and treatment per day.	<u>Network</u> No	$5	No	No
	<u>Non-Network</u> No	20%	Yes	Yes
Any combination of Network and Non-Network Benefits for Spinal Treatment is limited to 100 visits per calendar year.				
32. Temporomandibular Joint Services Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles. Diagnosis: Examination, radiographs and applicable imaging studies, and consultation. Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis, and trigger-point injections. Benefits are provided for surgical treatment if the following criteria are met: • There is clearly demonstrated radiographic evidence of significant joint abnormality. • Non-surgical treatment has failed to adequately resolve the symptoms. • Pain or dysfunction is moderate or severe. Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations, and TMJ implants. Any combination of Network and Non-Network Benefits is limited to $1,500 during the entire period of time you are covered under the Policy.	<u>Network</u> No	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.	
	<u>Non-Network</u> No	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.	

Description of Covered Health Service	Must You Notify United Healthcare?	Your Copayment Amount Copayments are based on a percent of Eligible Expenses. (*See definition of Eligible Expenses on page 79*)	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
33. Transplantation Services Covered Health Services for the following organ and tissue transplants when ordered by a Physician. For Network Benefits, transplantation services must be received at a Designated Facility. Benefits are available for the transplants listed	Network Yes	No Copayment	No	No
	Non-Network Yes	20%	Yes	Yes

below when the transplant meets the definition of a Covered Health Service, and is not an Experimental, Investigational or Unproven Service:

- Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service.
- Heart transplants.
- Heart/lung transplants.
- Lung transplants.
- Kidney transplants.
- Kidney/pancreas transplants.
- Liver transplants.
- Liver/small bowel transplants.
- Pancreas transplants.
- Small bowel transplants.

Benefits are also available for cornea transplants that are provided by a Physician at a Hospital. United Healthcare does not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits.

Coverage includes the treatment of breast cancer, lymphoma, and leukemia by dose-intensive chemotherapy/autologous bone marrow or stem cell transplants when performed in accordance with protocols approved by the institutional review board of any United States medical teaching college including, but not limited to, National Cancer Institute protocols that have been favorably reviewed and utilized by hematologists or oncologists experienced in such procedures.

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage.

United Healthcare has specific guidelines regarding Benefits for transplant services. Contact United Healthcare at the telephone number on your ID card for information about these guidelines.

Notify United Healthcare
For Network Benefits you or your Physician must notify United Healthcare as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you do not notify United Healthcare and if the transplantation services are not performed at a Designated Facility, you will be responsible for paying all charges and Network Benefits will be reduced to 50% of Eligible Expenses.

Please remember that for Non-Network Benefits you must notify United Healthcare as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't notify United Healthcare, Benefits will be reduced to 50% of Eligible Expenses.

34. Urgent Care Center Services Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this section.	Network No	$5 per visit	No	No
	Non-Network No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify United Healthcare?	Your Copayment Amount Copayments are based on a percent of Eligible Expenses. (*See definition of Eligible Expenses on page 79*)	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
35. Vision Examinations Eye examinations received from a health care provider in the provider's office. Benefits include one routine vision exam, including refraction, to detect vision impairment by a Network provider every other year.	<u>Network</u> No	$5 per visit	No	No
	<u>Non-Network</u> No	20%	Yes	Yes
Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses. Other vision benefits are available through the vision plan. Other Vision benefits may be available through the Vision Plan described in Attachment D.				

SECTION 3: What's Not Covered—Exclusions

This section contains information about:
• How headings are used in this section. • Medical services that are not covered. United Healthcare calls these Exclusions. It's important for you to know what services and supplies are not covered under the Policy.

How Headings Are Used in this Section

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

United Healthcare Does not Pay Benefits for Exclusions

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

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

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in (Section 2: What's Covered—Benefits) or through a Rider to the Policy.

A. Alternative Treatments

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

B. Comfort or Convenience

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

C. Dental

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

D. Drugs

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

E. Experimental, Investigational or Unproven Services

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

F. Foot Care

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

G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Prescribed or non-prescribed medical supplies and disposable supplies except as described in (Section 2: What's Covered –- Benefits) under the heading Diabetes Treatment. Examples include:

- Elastic stockings (except for jobe stockings).
- Ace bandages.
- Gauze and dressings.

3. Except as otherwise provided for in (Section 2: What's Covered – Benefits), orthotic appliances that straighten or re-shape a body part (including some types of braces) except cranial banding and cranial helmets.
4. Tubings and masks are not covered except when used with Durable Medical Equipment as described in (Section 2: What's Covered— Benefits).

H. Mental Health/Substance Abuse

1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
2. Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention.
3. Treatment for insomnia and other sleep disorders, dementia, neurological disorders and other disorders with a known physical basis.
4. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.
5. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
6. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee.
7. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following:

- Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.

- Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
- Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
- Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time.

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

I. Nutrition

1. Megavitamin and nutrition based therapy.
2. Nutritional counseling for either individuals or groups.
3. Except as described above under *Medical Foods* in (*Section 2: Covered Health Services),* enteral feedings, even if the sole source of nutrition.

J. Physical Appearance

1. Cosmetic Procedures. See the definition in (Section1: Key Terms). Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note:** Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in (Section 2: What's Covered—Benefits).
3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.

4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

K. Providers

1. Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:

– Has not been actively involved in your medical care prior to ordering the service, or

– Is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography testing.

L. Reproduction

1. Health services and associated expenses for infertility treatments.
2. Surrogate parenting.
3. The reversal of voluntary sterilization.
4. Fetal reduction surgery.

M. Services Provided under Another Plan

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

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

N. Transplants

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

O. Travel

1. Travel or transportation expenses to or from a foreign country, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

P. Vision

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

Q. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service—see the definition in (Section 1: Key Terms).
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:

- Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
- Related to judicial or administrative proceedings or orders.
- Conducted for purposes of medical research.
- Required to obtain or maintain a license of any type.

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

19. Medical and surgical treatment of excessive sweating (hyperhidrosis).
20. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
21. Oral appliances for snoring.
22. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly (except as provided in Section 2: What's Covered, Habilitative Services).

SECTION 4: Description of Network and Non-Network Benefits

This section contains information about:
• Network Benefits. • Non-Network Benefits. • Emergency Health Services.

Network Benefits

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

- Provided by or under the direction of a Network Physician or other Network provider in the Physician's office or at a Network facility.
- Emergency Health Services.

Please note that Mental Health and Substance Abuse Services must be authorized by the Mental Health/Substance Abuse Designee. Please see (Section 2: What's Covered—Benefits) under the heading for *Mental Health and Substance Abuse*.

Comparison of Network and Non-Network Benefits

	Network	Non-Network
Benefits	A higher level of Benefits means less cost to you. See (Section 2: What's Covered—Benefits).	A lower level of Benefits means more cost to you. See (Section 2: What's Covered—Benefits).
Who Should Notify United Healthcare for Care Coordination	Network providers generally handle notifying United Healthcare for you. However, there are exceptions. See (Section 2: What's Covered—Benefits), under the *Must You Notify United Healthcare?* column.	You must notify United Healthcare for certain Covered Health Services. Failure to notify results in reduced Benefits or no Benefits. See (Section 2: What's Covered—Benefits), under the *Must You Notify United Healthcare?* column.
Who Should File Claims	Not required. United Healthcare pays Network providers directly.	You must file claims. See (Section 5: How to File a Claim).
Outpatient Emergency Health Services	Emergency Health Services are always paid as a Network Benefit (paid the same whether you are in or out of the Network). That means that if you seek Emergency care at a non-Network facility, you are not required to meet the Annual Deductible or to pay any difference between Eligible Expenses and the amount the provider bills.	

Provider Network

United Healthcare arranges for health care providers to participate in a Network. Network providers are independent practitioners. They are not United Healthcare employees. It is your responsibility to select your provider.

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

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

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

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

Care Coordination℠

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

If you receive certain Covered Health Services from a Network provider, you must notify United Healthcare. The Covered Health Services for which notification is required is shown in (Section 2: What's Covered—Benefits). When you notify United Healthcare, United Healthcare will provide you the Care Coordination services described above.

Designated Facilities and Other Providers

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

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

Health Services from Non-Network Providers Paid as Network Benefits

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

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

Limitations on Selection of Providers

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

If you don't make a selection within 31 days of the date United Healthcare notifies you, United Healthcare will select a single Network Physician for you.

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

Termination of a Network Physician or Health Care Provider

If a Network Physician or health care provider's relationship with United Healthcare is terminated by either party for any reason other than termination of the Network Physician or the health care provider to meet applicable quality standards of care or fraud, and you are undergoing a course of treatment from the Physician at the time of termination, United Healthcare shall notify you on a timely basis of the termination. When medically necessary, persons with serious illness undergoing a course of treatment or who are in the second trimester of a pregnancy shall be permitted to continue to receive medically necessary covered services, with respect to the cause of treatment, by the physician or nurse midwife during the transitional period of ninety (90) days from the date of the notice under the same terms and conditions as specified under the provider contract.

Non-Network Benefits

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

- Provided by non-Network providers.
- Provided under the direction of a Non-Network Physician at a non-Network facility or program.

Notification Requirement

You must notify United Healthcare before getting certain Covered Health Services from non-Network providers. The details are shown in the *Must You Notify United Healthcare?* column in (Section 2: What's Covered—Benefits). If you fail to notify United Healthcare, Benefits are reduced or denied.

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

Care Coordination℠

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

Emergency Health Services

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

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

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

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

SECTION 5: How to File a Claim

This section provides you with information about:
• How and when to file a claim. • If you receive Covered Health Services from a Network provider, you do not have to file a claim. United Healthcare pays these providers directly. • If you receive Covered Health Services from a non-Network provider, you are responsible for filing a claim.

If You Receive Covered Health Services from a Network Provider

United Healthcare pays Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact United Healthcare. However, you are responsible for Copayments to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

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

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

If a Participant provides written authorization to allow this, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the Participant. But United Healthcare will not reimburse third parties who have purchased or been assigned benefits by Physicians or other providers.

Required Information

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

1. The Participant's name and address.
2. The patient's name and age.
3. The number stated on your ID card.
4. The name and address of the provider of the service(s).
5. A diagnosis from the Physician.
6. An itemized bill from your provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge.
7. The date the Injury or Sickness began.
8. A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

Payment of Benefits

United Healthcare will pay Benefits within 60 days after it receives your request for payment that includes all required information. Benefits will be paid to you unless either of the following is true:

1. The provider notifies United Healthcare that your signature is on file, assigning benefits directly to that provider.
2. You make a written request at the time you submit your claim.

ATTACHMENT B:

Prescription Drug Benefits

SECTION 1: Key Terms

This section:
• Defines the terms used throughout this Attachment B. • Is not intended to describe Benefits.

Brand-name

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

Designated Pharmacy

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

Generic

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

Network Pharmacy

A pharmacy that has:

- Entered into an agreement with United Healthcare or its designee to provide Prescription Drug Products to Covered Persons.

- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by United Healthcare as a Network Pharmacy.

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

New Prescription Drug Product

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

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

Predominant Reimbursement Rate

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

Prescription Drug Cost

The rate United Healthcare has agreed to pay our Network Pharmacies, including a dispensing fee and any sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List

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

Prescription Drug List Management Committee

The committee that United Healthcare designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product

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

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips—glucose;
  - urine-testing strips—glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices;
  - glucose monitors.

Prescription Order or Refill

The directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Usual and Customary Charge

The usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties.

SECTION 2: What's Covered—Prescription Drug Benefits

United Healthcare pays Benefits under the Policy for outpatient Prescription Drug Products:
• Designated as covered at the time the Prescription Order or Refill is dispensed when obtained from a Network or non-Network Pharmacy. • Refer to exclusions in (Section 3 of Attachment A) and as listed in (Section 3 of Attachment B).

Benefits for Outpatient Prescription Drug Products

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

When a Brand-name Drug Becomes Available as a Generic

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

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description of Pharmacy Type and Supply Limits" column of the Benefit Information table. For a single Copayment, you may receive a Prescription Drug Product up to the stated supply limit.

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

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

Notification Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to notify United Healthcare or its designee. The reason for notifying United Healthcare is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service.
- It is not Experimental, Investigational or Unproven.

NETWORK PHARMACY NOTIFICATION

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying United HealthCare.

NON-NETWORK PHARMACY NOTIFICATION

When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician are responsible for notifying United Healthcare as required.

If United Healthcare is not notified before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring notification are subject to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires notification through the Internet at www.myuhc.com or by calling the Customer Service number on your ID card.

If United Healthcare is not notified before the Prescription Drug Product is dispensed, you can ask United Healthcare to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Cost) will not be available to you at a non-Network Pharmacy. You may seek reimbursement from United Healthcare as described in Attachment A, (Section 5: How to File a Claim).

When you submit a claim on this basis, you may pay more because you did not notify United Healthcare before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost (for Prescription Drug Products from a Network Pharmacy) or the Predominant

Reimbursement Rate (for Prescription Drug Products from a non-Network Pharmacy), less the required Copayment and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after United Healthcare reviews the documentation provided and United Healthcare determines that the Prescription Drug Product is not a Covered Health Service or it is Experimental, Investigational or Unproven.

What You Must Pay

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

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

- Copayments for Prescription Drug Products.

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

Payment Information

Payment Term	Description	Amounts
Copayment	Copayments for a Prescription Drug Product at a Network Pharmacy can be either a specific dollar amount or a percentage of the Prescription Drug Cost. Copayments for a Prescription Drug Product at a non-Network Pharmacy can be either a specific dollar amount or a percentage of the Predominant Reimbursement Rate. Your Copayment is determined by the tier to which the Prescription Drug List Management Committee has assigned a Prescription Drug Product. NOTE: The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, your Copayment may change. Please access www.myuhc.com through the Internet, or call the Customer Service number on your ID card for the most up-to-date tier status.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment or • The Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug Product. For Prescription Drug Products from a home delivery Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment or • The Prescription Drug Cost for that Prescription Drug Product. *See the Copayments stated in the Benefit Information table for amounts.*

Benefit Information

Description of Pharmacy Type and Supply Limits	Your Copayment Amount
Prescription Drugs from a Retail Network Pharmacy Benefits are provided for outpatient Prescription Drug Products dispensed by a retail Network Pharmacy. The following supply limits apply: • As written by the provider, up to a consecutive 34-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Copayment for each cycle supplied.	Your Copayment is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access www.myuhc.com through the Internet, or call the Customer Service number on your ID card to determine tier status. For Active Employees and their Dependents: Tier 1: $1.00 per Prescription Order or Refill Tier 2 and 3: $15.00 per Prescription Order or Refill

Description of Pharmacy Type and Supply Limits	Your Copayment Amount
Prescription Drugs from a Retail Non-Network Pharmacy Benefits are provided for outpatient Prescription Drug Products dispensed by a retail non-Network Pharmacy. If the Prescription Drug Product is dispensed by a retail non-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with United Healthcare, as described in your Summary Plan Description. United Healthcare will not reimburse you for the difference between the Predominant Reimbursement Rate and the non-Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for that Prescription Drug Product. United Healthcare will not reimburse you for any non-covered drug product. In most cases, you will pay more if you obtain Prescription Drug Products from a non-Network Pharmacy. The following supply limits apply: • As written by the provider, up to a consecutive 34-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Copayment for each cycle supplied.	Your Copayment is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access www.myuhc.com through the Internet, or call the Customer Service number on your ID card to determine tier status. For Active Employees and their Dependents: Tier 1: $1.00 per Prescription Order or Refill Tier 2 and 3: $15.00 per Prescription Order or Refill

Description of Pharmacy Type and Supply Limits	Your Copayment Amount
Prescription Drug Products from a Home Delivery Network Pharmacy Benefits are provided for outpatient Prescription Drug Products dispensed by a home delivery Network Pharmacy. The following supply limits apply: • As written by the provider, up to a consecutive 102-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 102-day supply, with refills when appropriate. You will be charged a home delivery Copayment for any Prescription Orders or Refills sent to the home delivery pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or refill for a 102-day supply, not a 34-day supply with three refills.	Your Copayment is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access www.myuhc.com through the Internet, or call the Customer Service number on your ID card to determine tier status. For up to a 102 day supply, your Copayment is: For Active Employees and their Dependents: Tier 1: $0 per Prescription Order or Refill Tier 2 and 3: $15.00 per Prescription Order or Refill

SECTION 3: What's Not Covered—Exclusions

Exclusions from coverage listed in the Certificate apply also to this Attachment. In addition, the following exclusions apply:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment. This exclusion does not apply when the dispensed Prescription Drug Product is for an Eligible Person that resides outside the United States.
3. Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.
4. Experimental, Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by United HealthCare to be experimental, investigational or unproven.
5. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
6. Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
7. A specialty medication Prescription Drug Product (including, but not limited to, immunizations and allergy serum) which, due to its characteristics as determined by United HealthCare, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
8. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
9. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.

10. Unit dose packaging of Prescription Drug Products.
11. Medications used for cosmetic purposes.
12. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that are determined to not be a Covered Health Service.
13. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
14. Prescription Drug Products for smoking cessation, except nasal sprays and inhalers.
15. Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.
16. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug. Prescription Drug Products that are comprised of components that are available in over-the-counter form or equivalent.
17. New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our Prescription Drug List Management Committee.
18. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except Medical Foods included in the definition of a Prescriptions Drug Product.

Definition: Medical Foods and low protein modified food products when prescribed and administered under the direction of a Physician for the treatment of inherited metabolic diseases caused by an inherited abnormality of body chemistry. See *Medical Foods* in (Section 2: Schedule of Benefits in Attachment A) for more information.

ATTACHMENT C:

Dental Benefits

SECTION 1: Key Terms

This section defines the terms used throughout this Certificate and is not intended to describe Covered or uncovered services.

Amendment

Any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by United Healthcare. Amendments are subject to all conditions, limitations and exclusions of the Policy except for those, which are specifically amended.

Annual Maximum Benefit

The maximum amount paid for Covered Dental Services during a calendar year for a Covered Person under the Policy or any Policy, issued by United Healthcare to the Employer, that replaces the Policy. The Annual Maximum Benefit is stated in Section 2: Covered Dental Services.

Congenital Anomaly

A physical developmental defect that is present at birth, and is identified within the first twelve months of birth.

Copayment

The charge you are required to pay for certain Dental Services payable under the Policy. A Copayment may either be a defined dollar amount or a percentage of Eligible Expenses. You are responsible for the payment of any Copayment for Network Benefits directly to the provider of the Dental Service at the time of service or when billed by the provider.

Coverage or Covered

The entitlement by a Covered Person to reimbursement for expenses incurred for Dental Services covered under the Policy, subject to the terms, conditions, limitations and exclusions of the Policy. Dental Services must be provided: (1) when the Policy is in effect; and (2) prior to the date that any of the individual termination conditions as stated in the section entitled Termination of Coverage occur; and (3) only when the recipient is a Covered Person and meets all eligibility requirements specified in the Policy.

Covered Person

Either the Participant or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to “you” and “your” throughout this Attachment are references to a Covered Person.

Dental Service or “Dental Procedures”

Dental care or treatment provided by a Dentist to a Covered Person while the Policy is in effect, provided such care or treatment is recognized by United Healthcare as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dentist

Any dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render dental services, perform dental surgery or administer anesthetics for dental surgery.

Eligible Expenses

Eligible Expenses for Covered Dental Services, incurred while the Policy is in effect, are determined as stated below:

1. For Network Benefits, when Covered Dental Services are received from Network providers, Eligible Expenses are United Healthcare’s contracted fee(s) for Covered Dental Services with that provider.
2. For Non-Network Benefits, when Covered Dental Services are received from Non-Network providers, Eligible Expenses are the usual and customary fees as defined below.

In the event that a provider routinely waives Copayments and/or the Annual Deductible for Non-Network Benefits, Dental Services for which the Copayments and/or Annual Deductible are waived are not considered to be Eligible Expenses

Emergency

A dental condition or symptom resulting from dental disease which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, and such treatment is sought or received within 24 hours of onset.

Experimental, Investigational or Unproven Services

Medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time United Healthcare makes a determination regarding coverage in a particular case, is determined to be:

1. 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; or
2. Subject to review and approval by any institutional review board for the proposed use; or
3. 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; or
4. Not demonstrated through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Where a prescribed drug has not been approved by the FDA for this particular purpose, the Policy will include Coverage of such drug, provided:

1. The drug must have been recognized for the specific treatment for which it was prescribed in any of the following established reference compendia:
    a. The American Hospital Formulary Service Drug Information.
    b. The American Medical Association Drug Evaluations.
    c. The United States Pharmacopeia Drug Information, or
2. The drug was recommended for the specific treatment for which it was prescribed in major peer-reviewed professional medical journals, provided:
    a. Two articles have recognized the drug's safety and effectiveness for the treatment as prescribed, and
    b. No article has concluded that the drug is unsafe or ineffective for the treatment as prescribed.

Initial Eligibility Period

The initial period of time, determined by United Healthcare and the Plan Administrator, during which Eligible Persons may enroll themselves and Dependents under the Policy.

Medicare

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

Necessary

Dental care services and supplies which are determined by United Healthcare to be appropriate, and

1. necessary to meet the basic dental needs of the Covered Person; and
2. rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service; and
3. consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by United Healthcare; and
4. consistent with the diagnosis of the condition; and
5. required for reasons other than the convenience of the Covered Person or his or her Dentist; and
6. demonstrated through prevailing peer-reviewed medical and/or dental literature to be either:
    a. safe and effective for treating or diagnosing the condition or Sickness for which their use is proposed, or,
    b. safe with promising efficacy
        1) for treating a life threatening dental disease or condition,
        2) in a clinically controlled research setting; and
        3) using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

    (For the purpose of this definition, the term “life threatening” is used to describe a dental disease or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dentist has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this Certificate. The definition of Necessary used in this Certificate relates only to Coverage and differs from the way in which a Dentist engaged in the practice of dentistry may define necessary.

Network

A group of Dentists who are subject to a participation agreement in effect with United Healthcare, directly or through another entity, to provide Dental Services to Covered Persons. The participation status of providers will change from time to time.

Network Benefits

Benefits available for Covered Dental Services when provided by a Dentist who is a Network provider.

Non-Network Benefits

Coverage available for Dental Services obtained from Non-Network providers.

Physician

Any Doctor of Medicine, “M.D.,” or Doctor of Osteopathy, “D.O.,” who is duly licensed and qualified under the law of jurisdiction in which treatment is received.

Policy

The group Policy, the application of the Employer, Amendments and Riders which constitute the agreement regarding the benefits, exclusions and other conditions between United Healthcare and the Employer.

Procedure in Progress

All treatment for Covered Services that results from a recommendation and an exam by a Dentist. A treatment procedure will be considered to start on the date it is initiated and will end when the treatment is completed.

Rider

Any attached written description of Dental Services Covered under the Policy. Dental Services provided by a Rider may be subject to payment of additional Premiums and additional Copayments. Riders are effective only when signed by United Healthcare and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended.

Usual and Customary

Usual and Customary fees are calculated by United Healthcare based on available data resources of competitive fees in that geographic area.

Usual and Customary fees must not exceed the fees that the provider would charge any similarly situated payor for the same services. In the event that a provider routinely waives Copayments and/or the Annual Deductible for benefits, Dental Services for which the Copayments and/or the Annual Deductible are waived are not considered to be usual and customary.

Usual and Customary fees are determined solely in accordance with United Healthcare's reimbursement policy guidelines. United Healthcare's reimbursement policy guidelines are developed by United Healthcare, in its discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (publication of the American Dental Association);
- As reported by generally recognized professionals or publications;
- As utilized for Medicare;
- As determined by medical or dental staff and outside medical or dental consultants;
- Pursuant to other appropriate source or determination accepted by United Healthcare.

SECTION 2: Covered Dental Services

Dental Services

Dental Services described in this section are Covered when such services are:

1. Necessary (refer to the section entitled Definitions);
2. Provided by or under the direction of a Dentist or other appropriate provider as specifically described; and
3. Not excluded as described in the section entitled General Exclusions.

This Schedule of Covered Dental Services (1) describes the Covered Dental Services and any applicable limitation to each service, (2) outlines the Copayments that you are required to pay for each Covered Dental Service and (3) describes the Annual Deductible and any Annual Maximum Benefits that may apply.

Network Benefits

Network Benefits are subject to the payment of any Copayments listed below. Covered Dental Services must be provided by or directed by a Network Dentist.

When Network Copayments are charged as a percent of Eligible Expenses, the amount you pay for Dental Services from Network providers is determined as a percentage of the negotiated contract fee between United Healthcare and the provider rather than as a percentage of the provider's billed charge. United Healthcare's negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge a Covered Person or United Healthcare for any service or supply that is not Necessary as determined by United Healthcare. If a Covered Person agrees to receive a service or supply that is not Necessary the Network provider may charge the Covered Person. However, these charges will not be considered Covered Dental Services and will not be payable by United Healthcare.

Non-Network Benefits

Non-Network Benefits are subject to payment of Copayments listed below. When Copayments are charged as a percentage of the Usual and Customary fees, the amount you pay for Dental Services from Non-Network providers is determined as a percentage of the Usual and Customary fee **plus** the amount by which the Non-Network provider's billed charge exceeds the Usual and Customary fee.

Pre-Determination of Benefits

If the charge for a dental service is expected to exceed $200 or if a dental exam reveals the need for fixed bridgework or orthodontia, you should notify UnitedHealthcare before treatment begins. You must send notice to UnitedHealthcare, via a claim form, within 20 days of the exam. If requested, your dentist must provide UnitedHealthcare with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

UnitedHealthcare will decide if the proposed treatment is covered under the Policy and estimate the amount of the payment. The estimate of benefits payable will be sent to your dentist. If a treatment plan is not submitted, you will be responsible for payment of any dental treatment not approved by United Healthcare. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

This pre-determination of benefits procedure is not an agreement to pay for expenses – it simply lets you know in advance approximately what portion of the expenses will be considered for payment under the Plan.

Annual Maximum Benefit

Annual Maximum Benefit for preventive and non-preventive dental services described below is $3,000 per Covered Person.

After the first calendar year following the Covered Person's Effective Date, the Maximum Benefit per Covered Person may be increased by the carry over amount if:

a. the Covered Person has submitted a claim for an Eligible Expense incurred during the preceding calendar year; and

b. the reimbursement for the Eligible Expense incurred in the preceding calendar year did not exceed the benefit threshold.

In each succeeding calendar year in which the reimbursement for Eligible Expenses does not exceed the benefit threshold, the Covered Person will be eligible for the carry over amount. The carry over amount can be accumulated from one calendar year to the next up to the maximum carry over amount unless:

a. during any calendar year, Eligible Expenses are reimbursed in excess of the threshold. In this instance, there will be no additional carry over amount for the calendar year; or

b. during any calendar year, no claims for Eligible Expenses incurred during the preceding calendar year are submitted. In this instance, there will be no carry over amount for the calendar year.

Eligibility for the carry over amount will be established or reestablished at the time the first claim in a calendar year is received for Eligible Expenses incurred during the calendar year. In order to properly calculate the carry over amount, claims should be submitted timely in accordance with the proof of loss provision found within Section 4: Reimbursement.

You have the right to request review of prior carry over amount calculations. The request for review must be within 24 months from the date the carry over amount was established.

Orthodontic services

Orthodontic services are services or supplies furnished by a dentist in order to diagnose or correct misalignment of the teeth or the bite. Orthodontic services do not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, or a surgical procedure to correct a malocclusion.

The Lifetime Maximum Benefit for covered Orthodontic Services is $3,500 per Covered Person.

Preventive Dental Services

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT The Copayment is shown as a percentage of Eligible Expenses.	NON-NETWORK COPAYMENT The Copayment is shown as a percentage of Eligible Expenses. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Bacteriologic Cultures.	0%	20%
Bite-Wing Radiographs.	0%	20%
Complete Series or Panorex Radiographs.	0%	20%
Dental Prophylaxis.	0%	20%
Diagnostic Casts.	0%	20%
Extraoral Radiographs.	0%	20%
Fluoride Treatments. Treatment should be done in conjunction with dental prophylaxis.	0%	20%
Individual Periapical Radiographs.	0%	20%
Occlusal Radiographs.	0%	20%
Oral Examinations.	0%	20%
Sealants.	0%	20%

Non-Preventive Dental Services

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT The Copayment is shown as a percentage of Eligible Expenses.	NON-NETWORK COPAYMENT The Copayment is shown as a percentage of Eligible Expenses. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Minor Restorative Services		
Amalgam Restorations. Multiple restorations on one surface will be treated as a single filling.	20%	20%
Composite Resin Restorations. Multiple restorations on one surface will be treated as a single filling.	20%	20%
Space Maintainers		
Space Maintainers.	20%	20%
Endodontics		
Apexification.	20%	20%
Apicoectomy and Retrograde filling.	20%	20%
Hemisection.	20%	20%
Root Canal Therapy.	20%	20%
Root Resection.	20%	20%
Therapeutic Pulpotomy.	20%	20%
Periodontics		
Crown Lengthening.	20%	20%
Gingivectomy.	20%	20%
Osseous Graft.	20%	20%
Osseous Surgery	20%	20%
Periodontal Maintenance.	20%	20%
Provisional Splinting.	20%	20%
Scaling and Root Planing.	20%	20%
Soft Tissue Surgery	20%	20%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT The Copayment is shown as a percentage of Eligible Expenses.	NON-NETWORK COPAYMENT The Copayment is shown as a percentage of Eligible Expenses. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Oral Surgery		
Alveoloplasty.	20%	20%
Biopsy.	20%	20%
Frenectomy.	20%	20%
Incision and Drainage.	20%	20%
Removal of a Benign Cyst. Limited to once per site per visit	20%	20%
Root Recovery.	20%	20%
Root Removal.	20%	20%
Simple Extraction.	20%	20%
Surgical Extraction of Erupted Teeth and Roots.	20%	20%
Surgical Extraction of Impacted Teeth.	20%	20%
Adjunctive Services		
Analgesia.	20%	20%
Desensitizing Medicament.	20%	20%
General Anesthesia. Covered only when clinically necessary.	20%	20%
Intravenous Sedation and Analgesia.	20%	20%
Occlusal Adjustment.	20%	20%
Occlusal Guards.	20%	20%
Palliative Treatment. Covered as a separate benefit only if no other services, other than exam and radiographs, were done on the same tooth during the visit.	20%	20%

BENEFIT DESCRIPTION & LIMITATION	NETWORK COPAYMENT The Copayment is shown as a percentage of Eligible Expenses.	NON-NETWORK COPAYMENT The Copayment is shown as a percentage of Eligible Expenses. You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.
Major Restorative Services		
Crowns. Covered only when a filling cannot restore the tooth.	20%	20%
Gold Inlays and Onlays. Covered only when silver fillings cannot restore the tooth.	20%	20%
Pin Retention.	20%	20%
Porcelain Onlays.	20%	20%
Post and Cores. Covered only for teeth that have had root canal therapy.	20%	20%
Re-cement Crowns.	20%	20%
Re-cement Inlays.	20%	20%
Sedative Fillings. Covered as a separate benefit only if no other service, other than X-Rays and exam, were done on the same tooth during the visit.	20%	20%
Stainless Steel Crowns		
Stainless Steel Crowns.	20%	20%
Fixed Prosthetics		
Fixed Partial Dentures (Bridges).	20%	20%
Re-cement Bridges.	20%	20%
Removable Prosthetics		
Full Dentures.	20%	20%
Removable Partial Dentures.	20%	20%
Relining Dentures.	20%	20%
Repairs and adjustments to Full Dentures or Partial Fixed or Removable Dentures.	20%	20%

SECTION 3: General Exclusions

Exclusions

Except as may be specifically provided in the section entitled Covered Services or through a Rider to the Policy, the following are not Covered:

1. Dental Services that are not Necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Placement of dental implants, implant-supported abutments and prostheses. This includes pharmacological regimens and restorative materials not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Services for injuries or conditions covered by Workers' Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
11. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

12. Treatment of malignant or benign neoplasms, cysts, or other pathology, except excisional removal. Treatment of congenital malformations of hard or soft tissue, including excision.
13. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.
14. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
15. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
16. Expenses for dental procedures incurred prior to the Covered Person's eligibility with the Plan.
17. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
19. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
20. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
21. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
22. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. General Anesthesia, except if clinically necessary.
25. In the event that a Non-Network provider routinely waives Copayments and/or the Annual Deductible for a particular Dental Service, the Dental Service for which the Copayments and/or Annual Deductible are waived is not Covered.

SECTION 4: Reimbursement

United Healthcare shall reimburse you for Eligible Expenses subject to the terms; conditions, exclusions and limitations of the Policy and as described below.

Filing Claims for Reimbursement of Eligible Expenses

You are responsible for sending a request for reimbursement to United Healthcare, on a form provided by or satisfactory to the United Healthcare. Requests for reimbursement should be submitted within 90 days after date of service. Unless you are legally incapacitated, failure to provide this information to the United Healthcare within 1 year of the date of service shall cancel or reduce Coverage for the Dental Service.

Subject to written authorization from a Participant, all or a portion of any Eligible Expenses due may be paid directly to the provider of the Dental Services instead of being paid to the Participant.

Claim Forms

It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

1. Your name and address
2. Patient's name and age
3. Number stated on your ID card
4. The name and address of the provider of the service(s)
5. A diagnosis from the Dentist including a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim
6. Radiographs, lab or Hospital reports
7. Casts, molds or study models
8. Itemized bill which includes the Current Procedure Terminology (CPT) or American Dental Association (ADA) codes or description of each charge
9. The date the dental disease began.
10. A statement indicating that you are or you are not enrolled for coverage under any other health or dental insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

If you would like to use a claim form, call United Healthcare at the telephone number stated on your ID Card and a claim form will be sent to you. If you do not receive the claim form within 15 days of your request, send in the proof of loss with the information stated above.

Proof of Loss

Written proof of loss should be given to United Healthcare within 90 days after the date of the loss. If it was not reasonably possible to give written proof in the time required, United Healthcare will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service unless you are legally incapacitated.

Payment of Claims

Benefits are payable within 60 days after United Healthcare receives acceptable proof of loss. Benefits will be paid to you unless:

1. the provider notifies United Healthcare that your signature is on file assigning benefits directly to that provider; or
2. you make a written request at the time the claim is submitted.

Limitation of Action for Reimbursement

You do not have the right to bring any legal proceeding or action against United Healthcare to recover reimbursement until 90 days after you have properly submitted a request for reimbursement, as described above.

VISION BENEFITS

ATTACHMENT D:

Vision Benefits

SECTION 1: Covered Vision Services

General Information

You will be provided with benefits for each of the listed Services and Materials at the frequency stated in the Table of Benefits. Materials are lenses, frames, low vision aids and contact lenses. Vision Services include an examination, selection or fitting of glasses and related adjustments.

Examinations

Coverage shall include a vision survey examination of the condition of the eyes and principal vision functions, to include:

1. a case history; and
2. examination for eye pathology and abnormalities.

Post examination procedures shall only be performed when Materials are required.

Contact Lenses

In lieu of eyeglasses, you may receive contact lens Services. The Services and Materials include contact lenses, fitting and examination as shown in the Table of Benefits.

Contact lenses are medically necessary if you or your dependent has:

1. Keratoconus or irregular astigmatism;
2. Anisometropia of 3.50 diopters or more;
3. Post cataract surgery without intraocular lens; or
4. Visual acuity in the better eye of less than 20/70 with visual correction by eyeglasses but better than 20/70 with visual correction by contact lenses.

Network Providers Locations

To find a Network Provider, call the Spectera Locator Service at 1-800-839-3242, enter your postal zip code and a list of Network Providers will be provided. You may also access a listing of Network Providers on the Internet at www.spectera.com.

Laser Surgery

The benefit as shown in the Table of Benefits, which includes a complimentary eye evaluation and consultation to determine whether you or your dependent is a candidate for laser eye surgery.

TABLE OF BENEFITS

Service	Frequency of Service	Network Provider Co-payment *	Out of Network Maximum Benefit ***
Vision Exam	Once every two calendar years	$0.00	$300.00
Frames **	Once every two calendar years	$0.00	$300.00
Lenses (Any one type)	Once every two calendar years		
Single Vision		$0.00	$300.00
Bifocal Vision		$0.00	$300.00
Trifocal Vision		$0.00	$300.00
Lenticular Vision		$0.00	$300.00

*The Network Provider Co-payment will apply once if frames and lenses are purchased at the same time.

**Frames purchased from Network private practice Providers and Network retail optical Providers that are outside Spectera Selection will have a frame allowance. The frame allowance for a private practice provider is $50.00 wholesale and for a retail optical provider is $130.00 retail.

***The total reimbursement for all Out of Network Services, including but not limited to the Vision Exam, Frames, Lenses, and/or Contact Lenses, may not exceed $300.00.

Contact Lenses at a Network Provider: In lieu of lenses and a frame, you may select contact lenses. You will receive from a Spectera selection either one (1) pair of standard contact lenses or eight (8) boxes of covered disposables when obtained from a Network Provider. When you elect contact lenses from a Network Provider that are not from a Spectera selection, you will receive a $200.00 allowance that will be applied toward the evaluation, fitting and purchase of contact lenses once every two calendar years. In order to receive the full allowance, you must receive your exam, fitting and evaluation at the same Network Provider.

Contact Lenses at an Out-of-Network Provider: You may select contact lenses from an Out-of-Network Provider. We will pay a maximum benefit of $300.00 for elective contact lenses and $300.00 for necessary contact lenses. If your contact lenses are necessary the provider must submit to Spectera for approval prior to dispensing the contact lenses.

Laser Eye Surgery: Access to discounted refractive eye surgery procedures from a Spectera Laser Network Provider.

SECTION 2: General Exclusions

Exclusions

The following Services and Materials are excluded from coverage under the Policy:

1. Post cataract lenses;
2. Non-prescription items;
3. Medical or surgical treatment for eye disease, which requires the services of a physician;
4. Services or Materials for which the patient may be compensated under Worker's Compensation Law, or other similar employer liability law;
5. Services or Materials which the patient, without cost, obtains from any governmental organization or program;
6. Services and Materials which are not specifically covered by the Policy;
7. Replacement or repair of lenses and/or frames which have been lost or broken;
8. Cosmetic extras, except as stated in the Table of Benefits.

SECTION 3: Claims Procedure

Notice of Claim

Notice of claim must be given to United Healthcare (Spectera) within 365 days of the date such loss begins. The notice must be given with sufficient information to identify the patient. Failure to file such notice within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, the notice must be given as soon as reasonably possible.

Payment of Claims

Network Providers will accept your Co-payment for covered Services and Materials at the time of appointment. Network Providers will not bill you for covered Services in excess of Co-payment.

Reimbursement for Services or Materials received from providers who are not Network Providers will be made directly to you.

ATTACHMENT E:

Life Insurance &

Accidental Death and

Dismemberment Benefits

SECTION 1: Key Terms

Key Terms

The meaning of some of the terms used most frequently throughout this section, and not otherwise defined in Section 1 or Section 2, is explained below:

Assignment of Benefits

The transfer of ownership rights under a life insurance policy from one party to another.

Beneficiary

Your Beneficiary is the party or parties named by you, as shown on the Plan's records, to receive the benefits payable under this Plan upon your death.

Doctor

An individual licensed as a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.). The term "Doctor" shall also include any licensed or certified health care provider as required by state law, for services, which are within the scope of the health care provider's license or certificate.

Illness

A disorder or disease of the body or mind. Illness shall include: (a) pregnancy; (b) childbirth; and (c) related medical conditions. The Illness must first manifest itself while this benefit is in force.

Injury

Bodily harm that: (a) you sustain while this benefit is in force; and (b) is not the result of an Illness.

SECTION 2: General Information

General Information

The insurance benefits in this section are underwritten by The Union Labor Life Insurance Company (Union Labor Life). Life Insurance Benefits will be paid if you die while covered by the life insurance provisions of this Plan. Accidental Death and Dismemberment (AD&D) Benefits will be paid if you suffer an accidental Injury that results in a covered loss within 90 days of the accident. These benefits are described more fully in the rest of this Attachment E.

How do I designate my Beneficiary? Who can be my Beneficiary?

Your Beneficiary is the party or parties named by you, as shown on the Plan's records, to receive the benefits payable under this Plan upon your death. You may name one or more Beneficiaries to receive the death benefit.

You may change the Beneficiaries at any time, without the consent of the previously named Beneficiary. Such change must be requested in writing on a form furnished by or satisfactory to the Plan. Such change will take effect upon receipt of the signed form at the Plan Office.

If you and the named Beneficiary(ies) die at the same time and there is not sufficient evidence that you and the named Beneficiary(ies) have died other than simultaneously, the benefits payable under this Plan will be paid as if you had survived the named Beneficiary(ies).

Upon receipt of satisfactory proof of claim, the Claims Administrator will pay the Life Insurance and the Accidental Death and Dismemberment Benefits otherwise due to your named Beneficiary as follows:

1. If you have named more than one Beneficiary, each surviving Beneficiary will share equally, unless otherwise indicated by you when the Beneficiaries were named.
2. If there is no named Beneficiary, or if no named Beneficiary is surviving at the time of your death, payment will be made to the first surviving class in the following order of preference:
    a. your surviving spouse;
    b. your children, in equal shares;
    c. your parents, in equal shares;

d. your brothers and sisters, in equal shares; or

e. the executors or administrators of your estate.

In order to determine which class of individuals is entitled to the death benefit, the Claims Administrator may rely on an affidavit made by any individual listed above. If payment is made based on such affidavit, Union Labor Life will be discharged of its liability for the amount so paid, unless written notice of claim by another individual listed above is received before payment is made.

3. If the Beneficiary is a minor or someone not able to give a valid release for payment, the Claims Administrator will pay the benefit to his or her legal guardian. If there is no legal guardian, the Claims Administrator may pay the individual or institution who has, in its opinion, custody and principal support of such Beneficiary. Union Labor Life will be fully discharged of its liability for any amount of benefit so paid in good faith.

May I assign my benefits?

You may make an assignment of all the incidents of ownership of your Life Insurance Benefits, but only if Union Labor Life is given actual notice of the assignment. Any such assignment will not take effect with Union Labor Life prior to the date a copy of the assignment is received at its Home Office. Union Labor Life assumes no responsibility for the validity or sufficiency of any such assignment. Collateral assignments, by whatever name, are not permitted.

How do I or my Beneficiary apply for a benefit?

Information on applying for a benefit is discussed later in this section under the specific life insurance or AD&D insurance provisions.

What if my or my Beneficiary's claim for benefits is denied?

If all or a part of a claim is denied, Union Labor Life will send a written notice which explains the reasons for the denial. If you or your Beneficiary do not agree with the denial, a request can be made to review the claim. Such request must be in writing to Union Labor Life. The request for a review may:

- Request copies of all pertinent documents on which the claim decision was based (a written approval may be required to release confidential records, such as medical records); and
- Submit additional information to support the claim, including issues and comments in writing.

Union Labor Life will review and make a decision on the claim within 60 days from the later of the date the written request for review was received by Union Labor Life, or the date all additional information and comments are received by Union Labor Life. Union Labor Life will notify the individual making the request of its decision in writing, and will include clear and specific reasons for the decision.

A claimant or the claimant's authorized representative cannot start any legal action with respect to a claim until 60 days after proof of claim, as required above, has been given, or more than 3 years after the time proof of claim is required.

Life Insurance

The Life Insurance Benefit will be paid if a person dies while insured under this benefit.

What is the value of my Life Insurance Benefit?

The amount of benefit to be paid will be the Amount of Insurance as shown on the *Schedule of Benefits* section, which is in force for you on the date of your death, subject to all the terms and conditions of this Plan.

When will the Life Insurance Benefit payment be made?

The benefit will be paid to your named Beneficiary, upon receipt of due proof of death. Your Beneficiary should contact the Plan Office to initiate the process.

What is a proof of claim for Life Insurance Benefits?

Satisfactory proof of claim will include a certified copy of the individual's death certificate; and any other documentation that Union Labor Life determines in its discretion constitutes valid proof of death.

How are Life Insurance Benefits paid?

Proceeds will be paid to your Beneficiary in one lump sum unless you have elected to have the proceeds paid in installments under an optional plan that is then being offered by Union Labor Life. Details of such optional plans are available on request from the Union Labor Life. If you do not elect an optional plan for payment of death benefit proceeds, your Beneficiary may do so after your death.

The total benefit payable under this Plan for Life Insurance will never exceed the Amount of Insurance shown on the Schedule of Benefits section. In no event will payment be made under more than one of the following Life Insurance provisions:

1. Life Insurance Benefits;
2. Waiver of Premium; or
3. Conversion Privilege.

Accidental Death and Dismemberment Insurance (AD&D)

When will AD&D Benefits be paid?

Upon receipt of satisfactory proof of claim, Accidental Death and Dismemberment Benefits will be paid if:

1. you, while insured under this benefit, suffer an accidental Injury; and
2. as the direct result of the accident, and independent of all other causes, you suffer a Covered Loss within 90 days after the accident.

After an accidental Injury, you or your Beneficiary should contact the Plan Office to initiate the application process. For a covered loss, other than for loss of life, benefits shall be paid directly to you. In case of loss of life, benefits will be made to your Beneficiary.

A “Covered Loss” means permanent loss of:

1. life;
2. a hand, by severance at or above the wrist joint;
3. a foot, by severance at or above the ankle joint;
4. an eye, involving irrecoverable and complete loss of sight in the eye;

except as excluded under Exclusions in this section, and subject to all the terms and conditions of this Plan.

What is the value of my AD&D Benefit?

The amount of benefit to be paid for a Covered Loss is determined as follows:

Life	=	The Principal Sum
Two Feet	=	The Principal Sum
Two Hands	=	The Principal Sum

Sight of Two Eyes	=	The Principal Sum
One Hand and One Foot	=	The Principal Sum
One Hand and Sight of One Eye	=	The Principal Sum
One Foot and Sight of One Eye	=	The Principal Sum
One Hand or One Foot	=	50% of the Principal Sum
Sight of One Eye	=	50% of the Principal Sum

If you suffer more than one loss in any one accident, payment shall be made only for that loss for which the largest amount is payable.

The Principal Sum is set forth in Section 3: Schedule of Benefits.

What Exclusions Apply to the AD&D Benefit?

No AD&D benefit will be paid for any loss that is caused directly or indirectly, or in whole or in part, by any of the following:

1. Bodily or mental Illness or disease of any kind;
2. Ptomaines or bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound);
3. Suicide or attempted suicide while sane or insane;
4. Intentional self-inflicted injury;
5. Participation in, or the result of participation in, the commission of a felony, or a riot;
6. War or act of war, declared or undeclared; or any act related to war, or insurrection;
7. Service in the armed forces of any country while such country is engaged in war; or
8. Police duty as a member of any military, naval or air organization.

What is notice and proof of claim for AD&D Benefits?

In order to receive a claim form for filing a claim, written notice of a claim must be given to the Plan Office within 90 days after the date of loss which is covered under this Plan. Otherwise, the Plan Office must be notified as soon as reasonably possible thereafter.

Upon receipt of the written notice of claim, the Plan Office will provide claim forms for filing proof to the individual making a claim. If the individual does not receive the claim forms within 15 days after he or she sent notice of a claim, the

individual can file a claim without a claim form by sending the Plan Office written proof of claim.

Such written proof must include the information required as described below.

- Proof of the loss for which a claim is made must be given to the Plan Office no later than 90 days after the date of loss. A claim will not be reduced or denied for failure to provide proof within this time, if it is shown that it was not reasonably possible to furnish proof, and that proof was provided as soon as it was reasonably possible.
- The proof of loss must include all information necessary for Union Labor Life to determine the (1) nature of loss, and (2) date of loss.
- Union Labor Life may require, as part of the proof, authorization to obtain medical and non-medical information and will notify the individual of any additional information required to process a claim.

Union Labor Life, at its own expense, has the right to:

1. have the individual whose claim is pending examined by a Doctor of its choice; and
2. have an autopsy performed, if it is not prohibited by law.

Leave of Absence, Disability, and Termination of Coverage

What if I go on an approved leave of absence?

If you are on an approved leave of absence you may continue your Life and AD&D coverage by self-paying the required premium. In order to take advantage of this privilege, you must self-pay for the full amount of coverage as noted in the *Schedule of Benefits*. If you do not elect to continue your coverage during the approved leave of absence, you will have to satisfy the requirements for eligibility as a new employee in order to be eligible for coverage on your return to covered employment. It is your responsibility to notify the Plan if you intend to make self-payment.

What if I become disabled and am unable to work?

If you are unable to work because of a disability, you may be eligible for continued Life and AD&D coverage. You may elect to continue your insurance by making the required contributions. Any required self-payment must be received by the Plan Office no later than the 10th day of the first month in which you were no longer provided coverage by your employer for which the continued

coverage is intended. Subsequent self-payments for succeeding months must be consecutive and received by the 10th day of the month.

If your employer provides retiree coverage (see your Employer Participation Summary), and you are eligible to retire, continued coverage may apply under the retiree coverage provisions (see the Schedule of Benefits).

If you are under age 60, you may apply to continue your Life coverage under the Waiver of Premium provision if:

1. you become Totally Disabled while insured;
2. you have been Totally Disabled for at least 9 months, and
3. premium payments continue to be made for you or your coverage is terminated for failure to meet the eligibility requirements because of the Total Disability.

The initial continuation of insurance under the Waiver of Premium provision will be for 12 months from the earliest of the following dates: (1) the date premium payments on behalf of the insured person cease but not later than 24 months from the date Total Disability began, (2) the date the Total Disability began, or (3) the date the application for waiver is approved. Waiver of Premium will continue until the insured person's Total Disability ends, up to the end of the 12-month period.

The insured person must submit satisfactory written proof (the "Initial Proof") of Total Disability within 12 months from the date the that the Total Disability began or, if later, 12 months from the date the premium payments on behalf of such insured person cease (but in no event later than 24 months from the date Total Disability began). The Initial Proof must show that the Total Disability:

1. began while the insured person was insured under this Attachment E,
2. began before the attainment of age 60, and
3. has rendered the insured person Totally Disabled for at least 9 consecutive months.

Union Labor Life will give written notice within 10 days of receipt of an application for a Waiver of Premium. The notice will state whether or not the application is approved and give the reasons for any disapproval. If the application for waiver is disapproved, the insured person may be entitled to the same conversion rights that applied to the insured person on the date his or her Life Insurance would have terminated in the absence of this Waiver of Premium provision.

An insured person who has applied for and received approval of Waiver of Premium for the Life Insurance Benefit, may continue the Waiver of Premium for additional 12-month periods, provided the insured person remains Totally

Disabled and submits written proof of continued Total Disability each year within 3 months of the anniversary of the date the insured person becomes Totally Disabled.

Union Labor Life, at its own expense, may require an insured person whose Life Insurance has been continued by this Waiver of Premium, to be examined by a Physician of its choice, at any reasonable time during the insured person's first two years of Total Disability. After two years, Union Labor Life will not require such examination more than once a year.

If an insured person applies for a Waiver of Premium and dies before the Waiver of Premium is in effect, the Beneficiary must submit written proof that Total Disability continued without interruption from the date the insured person became Totally Disabled to the date of death.

If an insured person dies while this Waiver of Premium is in effect, the Beneficiary must submit written proof that Total Disability continued without interruption from the last anniversary of Union Labor Life's receipt of proof to the date of death.

If I am Totally Disabled and am Covered Under the Waiver of Premium, what will be the Benefit Amount?

The amount of Life Insurance continued under the Waiver of Premium will be the Amount of Insurance in force for the insured person on the date he or she became Totally Disabled. The amount of Life Insurance continued under this Waiver of Premium is subject to any reduction or termination in the Amount of Insurance for active employees. An insured person who is approved for Waiver of Premium under this provision and holds an individual policy of life insurance through exercise of the Conversion provision described below, is not entitled to receive benefits under both this Plan and the individual conversion policy for the same amounts of insurance. At the time of the insured person's death, payment will be made under this Plan only if the individual policy is surrendered to Union Labor Life without claim other than for return of the premiums paid, less dividends.

If my coverage under this Plan terminates or lessens, what are my Conversion rights?

If your Life Insurance Benefit, or any portion thereof, terminates, you are entitled to convert all or a portion of the Amount of Insurance which has been terminated. This conversion will be to an individual policy of Life Insurance ("Conversion Policy"). You will not be required to submit proof of good health to convert.

If your Life Insurance Benefit, or any portion thereof, terminates because:

1. You cease to be eligible under the “Who is Eligible” section in the Eligibility Rules, or
2. You transfer from one eligible class to another, and the class to which you transferred offers you less benefits,

you may convert up to the amount of Life Insurance which terminated, less any amount for which you become eligible under this Plan or under any other group plan within 31 days from the date of termination.

If your Life Insurance Benefit is reduced because of age or retirement, you may convert up to the amount of the reduction.

If your Life Insurance Benefit terminates because:

1. this Plan terminates, or
2. this Plan is amended to terminate coverage for an eligible class under which you were insured,

you may convert to an amount that does not exceed the lesser of the following, provided you have been continuously insured for the Life Insurance Benefit of this Plan (or the plan which this Plan replaced) for at least five years:

1. the Amount of Life Insurance Benefit in effect for you on the date of termination, less any amount for which you are or become eligible under this Plan or any other group plan (which replaces this Plan) within 31 days after the date of termination; or
2. $2,000.

When does Conversion Notice have to be given to Union Labor Life?

The Plan must notify you of your right to convert. If the notice is not given by the 16th day of the 31-day conversion period, you will have an additional period in which to convert. The additional period will expire 15 days from the date you are notified, but in no event will the right to convert be extended more than 91 days beyond the date your insurance terminated under this Plan. Written notice presented to you, or mailed to your last known address, shall constitute notice for purpose of this provision.

In no event is the individual’s Life Insurance Benefit extended beyond the end of the 31-day conversion period, whether or not notice is given.

How do I qualify for a Conversion Policy?

To qualify for a Conversion Policy, an individual must submit a written application to Union Labor Life and pay the first premium due within 31 days from the date your Life Insurance Benefit terminates under this Plan, unless an additional period in which to convert has been granted as shown in the Notice of Conversion Policy in this section.

You will be entitled to convert to any individual policy which is then being offered by Union Labor Life, other than term insurance, or insurance which provides disability or other supplemental benefits.

If you die during the 31-day conversion period, the maximum amount of insurance which you were entitled to convert will be paid as a benefit to the last Beneficiary named by you, whether or not conversion was applied for and premium paid. If a Conversion Policy was applied for, such policy will be null and void, even if the policy had been issued, and no death claim will be payable under the Conversion Policy. Union Labor Life will return any premium paid for the Conversion Policy.

What are the premiums for a Conversion Policy?

The premium rates for the Conversion Policy will be Union Labor Life's premium rates in effect for the amount and type of policy elected and based on your class of risk (gender) and attained age (age nearest birthday at the date of issue of the Conversion Policy) on the effective date of the Conversion Policy.

Plan 4:	Active Employees: 100% of salary, not to exceed $40,000, except for: • If annual salary is less than $20,000, then 100% of salary plus $3,000. • If annual salary is between $20,000 and $23,000, then $23,000. Retired Employees: Coverage reduced to 50% of amount in force on the day before retirement. If a person retires due to a Total Disability, coverage will remain at the Amount of Life Insurance in force on the date Total Disability began if the person self-pays or, if the person is under age 60, supplies information and is approved for a Waiver of Premium.	Active Employees: Same as Amount of Life Insurance. Retired Employees: Same as Amount of Life Insurance. Total Disability: Coverage reduced to 50% of amount in force on the date Total Disability began.

AFL-CIO Health & Welfare Plan – Fire Fighters
EMPLOYER PARTICIPATION SUMMARY

THE INTERNATIONAL ASSOCIATION OF FIRE FIGHTERS (IAFF)	BENEFITS	EMPLOYEE CONTRIBUTIONS	SPECIAL ELIGIBILITY RULES
Medical coverage for active employees	Yes	No	N/A
Life and AD&D coverage for active employees	Plan 4	No	N/A
Medical coverage for retired employees	Yes Provided Under the AFL-CIO Health & Welfare Fund	None	• Subject to collective bargaining, retiree must: ➢ be actively employed by the IAFF on the day before retirement, and ➢ receive an immediate pension benefit from the IAFF pension plan. • Surviving spouse coverage if the surviving spouse receives a survivor benefit under the IAFF pension plan • Surviving dependent coverage continues until the last day of the month in which the dependent child would otherwise no longer meet the definition of dependent.
Life and AD&D coverage for retired employees	Yes - Plan 4 Provided Under the AFL-CIO Health & Welfare Fund	None	Subject to collective bargaining, retiree must: ➢ be actively employed by the IAFF on the day before retirement, and ➢ receive an immediate pension benefit from the IAFF pension plan.

Please note that these rules describe the provisions governing the participation of the International Association of Fire Fighters (the "Employer") in the AFL-CIO Health & Welfare Plan (the "Plan") as of August 1, 2007, and may be modified by the Employer at any time subject to the consent of the Fund's Board of Trustees, the terms of any applicable collective bargaining agreement, and any other legal obligation of the Employer.