

**Summary Plan Description**  
**PPO Medicare Supplemental Plan**  
**for**  
**Washington Suburban Sanitary Commission**

Group Number: 712974  
Effective Date: January 1, 2012



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# Introduction

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

## How to Use this Document

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

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

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

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

## Information about Defined Terms

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

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

## Your Contribution to the Benefit Costs

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

## Customer Service and Claims Submittal

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

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

**Prior Notification:** As shown on your ID card.

**Mental Health/Substance Use Disorder Services Designee:** As shown on your ID card.

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**Claims Submittal Address:**

United HealthCare Services, Inc.

P.O. Box 740800

Atlanta, Georgia 30374-0800

**Requests for Review of Denied Claims and Notice of Complaints:**

Name and Address For Submitting Requests:

United HealthCare Services, Inc.

P.O. Box 740816

Atlanta, Georgia 30374-0816

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# Section 1: What's Covered--Benefits

This section provides you with information about:

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

## Accessing Benefits

You can choose to receive Benefits from any Physician or provider.

Depending on the geographic area, you may have access to Network providers. These providers have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from a Network provider, your Copayment level will remain the same. However, the portion that you owe may be less than if you received services from a non-Network provider because the Eligible Expense may be a lesser amount.

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You should show your identification card (ID card) every time you request health care services so that the provider will know that you are enrolled under the Plan.

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

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

## Copayment

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

## Eligible Expenses

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

We have delegated to the Claims Administrator the discretion and authority to determine on our behalf whether a treatment or supply

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is a Covered Health Service and how the Eligible Expense will be determined and otherwise covered under the Plan.

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

## Notification Requirements

Prior notification is required before you receive certain Covered Health Services. You are responsible for notifying the Claims Administrator before you receive these Covered Health Services.

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

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

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

- The Cosmetic Procedures exclusion. Examples of procedures that may or may not be considered Cosmetic include: breast

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reduction and reconstruction (except for after cancer surgery when it is always considered a Covered Health Service); vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty.

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

## Special Note Regarding Mental Health and Substance Use Disorder Services

You must provide pre-service notification as described below.

When Benefits are provided for any of the services listed below, pre-service notification is required:

- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home.
- Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders -inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.
- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program

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treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

For a scheduled admission, you must notify the Mental Health/Substance Use Disorder Administrator prior to the admission, or as soon as reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to notify the Mental Health/Substance Use Disorder Administrator as required, Benefits will be reduced to 35% of Eligible Expenses.

In addition, you must notify the Mental Health/Substance Use Disorder Administrator before the following services are received. If you fail to notify the Mental Health/Substance Use Disorder Administrator as required, Benefits will be reduced to 35% of Eligible Expenses.

Services requiring prior notification are:

- Intensive outpatient program treatment.
- Outpatient electro-convulsive treatment.
- Psychological testing.
- Outpatient treatment of opioid dependence.
- Extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

### ***Special Mental Health and Substance Use Disorder Programs and Services***

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Mental Health and Substance Use Disorder Services benefits. The Mental Health and Substance Use Disorder Services Benefits and financial requirements assigned to

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these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness or substance use disorder which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

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## Payment Information

Payment Term	Description	Amounts
<b>Annual Deductible</b>	The amount you pay for Covered Health Services before you are eligible to receive Benefits.	No Annual Deductible.
<b>Out-of-Pocket Maximum</b>	The maximum you pay, out of your pocket, in a calendar year for Copayments.	No Out-of-Pocket Maximum.

Payment Term	Description	Amounts
<b>Maximum Plan Benefit</b>	<p>There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.</p> <p>Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.</p>	No Maximum Plan Benefit.

# Benefit Information

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>
<p><b>1. Ambulance Services - Emergency only</b> Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.</p>	No	<p><i>Ground Transportation:</i> 0%</p> <p><i>Air Transportation:</i> 0%</p>
<p><b>2. Dental Services - Accident only</b> Dental services when all of the following are true:</p> <ul style="list-style-type: none"> <li>• Treatment is necessary because of accidental damage.</li> <li>• Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D."</li> <li>• The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident.</li> </ul> <p>Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was:</p> <ul style="list-style-type: none"> <li>• A virgin or unrestored tooth, or</li> <li>• 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.</li> </ul> <p>Dental services for final treatment to repair the damage must be</p>	Yes	0% ?

**Description of  
Covered Health Service**

**Must  
You  
Notify the  
Claims  
Administrator?**

**Your Copayment  
Amount**

% Copayments are  
based on a percent of  
Eligible Expenses

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both of the following:

- Started within three months of the accident.
- Completed within 12 months of the accident.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities.

**Notify the Claims Administrator**

Please remember that you must notify the Claims Administrator as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. (You do not have to provide notification before the initial Emergency treatment.) If you don't notify the Claims Administrator, Benefits will be reduced to 50% of Eligible Expenses.

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>
<p><b>3. Durable Medical Equipment</b></p> <p>Durable Medical Equipment that meets each of the following criteria:</p> <ul style="list-style-type: none"> <li>• Ordered or provided by a Physician for outpatient use.</li> <li>• Used for medical purposes.</li> <li>• Not consumable or disposable.</li> <li>• Not of use to a person in the absence of a disease or disability.</li> </ul>	Yes, for items more than \$1,000.	0%
<p>If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment.</p>		
<p>Examples of Durable Medical Equipment include:</p>		
<ul style="list-style-type: none"> <li>• Equipment to assist mobility, such as a standard wheelchair.</li> <li>• A standard Hospital-type bed.</li> <li>• Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).</li> <li>• Delivery pumps for tube feedings (including tubing and connectors).</li> <li>• Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, except for, podiatric appliances for the prevention of complications associated with diabetes, and</li> </ul>		

**Description of  
Covered Health Service**

**Must  
You  
Notify the  
Claims  
Administrator?**

**Your Copayment  
Amount**

% Copayments are based on a percent of Eligible Expenses

are excluded from coverage. Dental braces are also excluded from coverage.

- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Podiatric appliances including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes.

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

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

Benefits for Durable Medical Equipment are limited to \$2,500 per calendar year.

**Notify the Claims Administrator**

Please remember that you must notify the Claims Administrator before obtaining any single item of Durable Medical Equipment that costs more than \$1,000 (either purchase price or cumulative rental of a single item). If you don't notify the Claims Administrator, you will be responsible for paying all charges and no Benefits will be paid.

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>
<p><b>4. Emergency Health Services</b></p> <p>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.</p> <p>You will find more information about Benefits for Emergency Health Services in (Section 3: Obtaining Benefits).</p> <p style="text-align: center;"><b>Notify the Claims Administrator</b></p> <p>Please remember that if you are admitted to a Hospital as a result of an Emergency, you must notify the Claims Administrator within one business day or the same day of admission, or as soon as reasonably possible.</p> <p>If you don't notify the Claims Administrator, Benefits for the Hospital Inpatient Stay will be reduced to 50% of Eligible Expenses. Benefits will not be reduced for the outpatient Emergency Health Services.</p>	Yes, but only for an Inpatient Stay.	0%
<p><b>5. Eye Examinations</b></p> <p>Eye examinations received from a health care provider in the provider's office. Benefits include one refraction exam to detect vision impairment every other calendar year.</p> <p>Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.</p> <p>For questions on claims please contact <b>UHC Vision Customer Service Unit at 1-877-426-9300.</b></p>	No	\$25

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>
Hardware- Customer has a <b>discount</b> for the purchase or fitting of eyeglasses or contact lenses at a Network provider. For details contact <b>UHC Vision Customer Service Unit</b> at <b>1-877-426-9300</b> .		

## 6. Home Health Care

Yes

0%

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.

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.

**Description of  
Covered Health Service**

**Must  
You  
Notify the  
Claims  
Administrator?**

**Your Copayment  
Amount**

% Copayments are  
based on a percent of  
Eligible Expenses

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

Benefits are limited to 120 visits per calendar year. One visit equals four hours of skilled care services.

**Notify the Claims Administrator**

Please remember that you must notify the Claims Administrator five business days before receiving services. If you don't notify the Claims Administrator, Benefits will be reduced to 50% of Eligible Expenses.

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**7. Hospice Care**

Yes

0%

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

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

Benefits are limited to 360 days during the entire period of time you

**Description of Covered Health Service**

**Must You Notify the Claims Administrator?**

**Your Copayment Amount**

% Copayments are based on a percent of Eligible Expenses

are covered under the Plan.

**Notify the Claims Administrator**

Please remember that you must notify the Claims Administrator five business days before receiving services. If you don't notify the Claims Administrator, Benefits will be reduced to 50% of Eligible Expenses.

**8. Hospital - Inpatient Stay**

Yes

0%

Inpatient Stay in a Hospital. Benefits are available for:

- Services and supplies received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).

**Notify the Claims Administrator**

Please remember that you must notify the Claims Administrator as follows:

- For elective admissions: five business days before admission.
- For non-elective admissions: within one business day or the same day of admission.
- For Emergency admissions: within one business day or the same day of admission, or as soon as is reasonably possible.

If you don't notify the Claims Administrator, Benefits will be reduced to 50% of Eligible Expenses.

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>
<p><b>9. Injections received in a Physician's Office</b></p> <p>Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.</p>	No	0% per injection
<p><b>10. Maternity Services</b></p> <p>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.</p> <p>There are special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the programs. To sign up, you should notify the Claims Administrator during the first trimester, but no later than one month prior to the anticipated childbirth.</p> <p>We will pay Benefits for an Inpatient Stay of at least:</p> <ul style="list-style-type: none"> <li>• 48 hours for the mother and newborn child following a normal vaginal delivery.</li> <li>• 96 hours for the mother and newborn child following a cesarean section delivery.</li> </ul> <p>If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time</p>	Yes if Inpatient Stay exceeds time frames.	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.

**Description of Covered Health Service**

**Must You Notify the Claims Administrator?**

**Your Copayment Amount**

% Copayments are based on a percent of Eligible Expenses

frames.

**Notify the Claims Administrator**

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

**11. Mental Health Services**

Mental Health Services include those received on an inpatient basis in a Hospital or Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an outpatient or inpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication Management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient

You must notify the MH/SUD Administrator as outlined under "Notification Required".

0%

**Description of  
Covered Health Service**

**Must  
You  
Notify the  
Claims  
Administrator?**

**Your Copayment  
Amount**

% Copayments are  
based on a percent of  
Eligible Expenses

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basis:

- Partial hospitalization/day treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services on an outpatient basis:

- Intensive outpatient treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

**Notification Required**

Please remember that you must notify the MH/SUD Administrator to receive these Benefits in advance of any treatment. Please call the phone number that appears on your ID card.

Without notification, Benefits will be reduced to 50% of Eligible Expenses.

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>
<p><b>12. Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders</b></p> <p>The Plan pays Benefits for psychiatric services for Autism Spectrum Disorders that are both of the following:</p> <ul style="list-style-type: none"> <li>• Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.</li> <li>• Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.</li> </ul> <p>These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.</p> <p>Benefits include the following services provided on either an outpatient or inpatient basis:</p> <ul style="list-style-type: none"> <li>• Diagnostic evaluations and assessment.</li> <li>• Treatment planning.</li> <li>• Referral services.</li> <li>• Medication management.</li> <li>• Individual, family, therapeutic group and provider-based case management services.</li> </ul>	<p>You must notify the MH/SUD Administrator as outlined under "Notification Required".</p>	<p>0%</p>

**Description of  
Covered Health Service**

**Must  
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Notify the  
Claims  
Administrator?**

**Your Copayment  
Amount**

% Copayments are  
based on a percent of  
Eligible Expenses

- Crisis intervention.

Benefits include the following services provided on an inpatient basis.

- Partial Hospitalization/Day Treatment.

- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

**Notification Required**

Please remember that you must notify the MH/SUD Administrator to receive these Benefits in advance of any treatment. Please call the phone number that appears on your ID card.

Without notification, Benefits will be reduced to 50% of Eligible Expenses.

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>
<p><b>13. Ostomy Supplies</b></p> <p>Benefits for ostomy supplies include only the following:</p> <ul style="list-style-type: none"> <li>• Pouches, face plates and belts.</li> <li>• Irrigation sleeves, bags and catheters.</li> <li>• Skin barriers.</li> </ul> <p>Benefits are not available for gauze, adhesive, adhesive remover, deodorant, pouch covers, or other items not listed above.</p>	No	0%
<p><b>14. Outpatient Surgery, Diagnostic and Therapeutic Services</b></p> <p>Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:</p> <ul style="list-style-type: none"> <li>• Surgery and related services.</li> <li>• Lab and radiology/X-ray.</li> <li>• Mammography testing.</li> <li>• Other diagnostic tests and therapeutic treatments (including cancer chemotherapy or intravenous infusion therapy).</li> </ul> <p>Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient surgery, diagnostic and therapeutic services are described under <i>Professional Fees for Surgical and Medical Services</i> below.</p>	No	0%

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> below.		
<p><b>15. Physician's Office Services</b></p> <p>Covered Health Services received in a Physician's office including:</p> <ul style="list-style-type: none"> <li>• Treatment of a Sickness or Injury.</li> <li>• Preventive medical care.</li> <li>• Voluntary family planning.</li> <li>• Well-baby and well-child care.</li> <li>• Routine physical examinations.</li> <li>• Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment. See <i>Eye Examinations</i> earlier in this section.)</li> <li>• Immunizations.</li> </ul>	No	0%
<p><b>16. Professional Fees for Surgical and Medical Services</b></p> <p>Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility.</p> <p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> above.</p>	No	0%

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
<p><b>17. Prosthetic Devices</b></p> <p>Prosthetic devices that replace a limb or body part including:</p> <ul style="list-style-type: none"> <li>• Artificial limbs.</li> <li>• Artificial eyes.</li> <li>• Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998.</li> </ul> <p>If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.</p> <p>The prosthetic device must be ordered or provided by, or under the direction of a Physician. Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every three calendar years.</p> <p>Benefits for prosthetic devices are limited to \$2,500 per calendar year.</p>	No	0%
<p><b>18. Reconstructive Procedures</b></p> <p>Services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function.</p>	Yes	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.

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Eligible Expenses

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 the Claims Administrator at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

**Notify the Claims Administrator**

Please remember that you must notify the Claims Administrator five business days before receiving services. When you provide notification, the Claims Administrator can verify that the service is a reconstructive procedure rather than a Cosmetic Procedure. Cosmetic Procedures are always excluded from coverage. If you don't notify the Claims Administrator, Benefits for reconstructive procedures will be reduced to 50% of Eligible Expenses.

Description of  
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based on a percent of  
Eligible Expenses

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## 19. Rehabilitation Services - Outpatient Therapy

No

0%

Short-term outpatient rehabilitation services for:

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.

Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician.

Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment.

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

Benefits are limited as follows:

- 60 visits of physical therapy per calendar year.
- 60 visits of occupational therapy per calendar year.
- 60 visits of speech therapy per calendar year.
- 60 visits of pulmonary rehabilitation therapy per calendar year.
- 60 visits of cardiac rehabilitation therapy per calendar year.

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>
<p><b>20. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</b></p> <p>Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:</p> <ul style="list-style-type: none"> <li>• Services and supplies received during the Inpatient Stay.</li> <li>• Room and board in a Semi-private Room (a room with two or more beds).</li> </ul> <p>Benefits are limited to 60 days per calendar year.</p> <p>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.</p> <p style="text-align: center;"><b>Notify the Claims Administrator</b></p> <p>Please remember that you must notify the Claims Administrator as follows:</p> <ul style="list-style-type: none"> <li>• For elective admissions: five business days before admission.</li> <li>• For non-elective admission: within one business day or the same day of admission.</li> <li>• For Emergency admissions: within one business day or the same day of admission, or as soon as is reasonably possible.</li> </ul> <p>If you don't notify the Claims Administrator, Benefits will be reduced to 50% of Eligible Expenses.</p>	Yes	0%

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>
<p><b>21. Spinal Treatment</b></p> <p>Benefits for Spinal Treatment when provided by a Spinal Treatment provider in the provider's office.</p> <p>Benefits include diagnosis and related services and are limited to one visit and treatment per day.</p> <p>Benefits for Spinal Treatment are limited to 24 visits per calendar year.</p>	No	0%
<p><b>22. Substance Use Disorder Services</b></p> <p>Substance Use Disorder Services include those received on an inpatient basis in a Hospital or an Alternate Facility and those received on an outpatient basis in a provider's office or at an Alternate Facility.</p> <p>Benefits include the following services provided on either an inpatient or outpatient basis:</p> <ul style="list-style-type: none"> <li>• Diagnostic evaluations and assessment.</li> <li>• Treatment planning.</li> <li>• Referral services.</li> <li>• Medication management.</li> <li>• Individual, family, therapeutic group and provider-based case management.</li> <li>• Crisis intervention.</li> </ul>	You must notify the MH/SUD Administrator as outlined under "Notification Required".	0%

**Description of  
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Eligible Expenses

- Detoxification (sub-acute/non-medical).

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

**Notification Required**

Please remember that you must notify the MH/SUD Administrator to receive these Benefits in advance of any treatment. Please call the phone number that appears on your ID card.

Without notification, Benefits will be reduced to 50% of Eligible Expenses.

**Description of  
Covered Health Service**

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Administrator?**

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Amount**

% Copayments are  
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Eligible Expenses

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## 23. Transplantation Services

Yes

0%

Covered Health Services for the following organ and tissue transplants when ordered by a Physician. Benefits are available for the transplants listed below when the transplant meets the definition of a Covered Health Service, and is not an Experimental, Investigational or Unproven Service:

- Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service.
- 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.

Organ or tissue transplants or multiple organ transplants other than

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those listed above are excluded from coverage.

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

**Notify the Claims Administrator**

You must notify the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't notify the Claims Administrator, Benefits will be reduced to 50% of Eligible Expenses.

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**24. Urgent Care Center Services**

No

0%

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.

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## Section 2: What's Not Covered-- Exclusions

This section contains information about:

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

### How We Use Headings in this Section

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

### We Do not Pay Benefits for Exclusions

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

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

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

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

### A. Alternative Treatments

1. Acupuncture.
2. Acupressure.
3. Aroma therapy.
4. Hypnotism.
5. Massage Therapy.
6. Rolfing.
7. 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.

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## C. Dental

1. Dental care except as described in (Section 1: What's Covered--Benefits) under the heading *Dental Services - Accident Only*.
2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
  - Extraction, restoration and replacement of teeth.
  - Medical or surgical treatments of dental conditions.
  - Services to improve dental clinical outcomes.
3. Dental implants.
4. Dental braces.
5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:
  - Transplant preparation.
  - Initiation of immunosuppressives.
  - 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.

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## 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.
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. Examples include:
  - Elastic stockings.

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- Ace bandages.
  - Gauze and dressings.
  - Syringes.
  - Diabetic test strips.
3. Orthotic appliances that straighten or re-shape a body part (including some types of braces).
  4. Tubings and masks are not covered except when used with Durable Medical Equipment (as described in Section 1: What's Covered--Benefits).

## H. Mental Health/Substance Use Disorder

Exclusions listed directly below apply to services described under *Mental Health Services* and/or *Substance Use Disorder Services* as described in (Section 1: What's Covered--Benefits).

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:
  - not consistent with generally accepted standards of medical practice for the treatment of such conditions;
  - not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental;

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

- not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or
  - not clinically appropriate in terms of type, frequency, extent, site and duration of treatment, and considered ineffective for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.
3. Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
  4. Mental Health Services as treatment for a primary diagnosis of insomnia other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.
  5. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) 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 determined by the Mental Health/Substance Use Disorder Administrator.
  6. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
  7. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.
  8. Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

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9. Mental retardation as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
10. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction.
11. Intensive behavioral therapies such as applied behavioral analysis and Lovaas Therapy for Autism Spectrum Disorders.
12. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

## I. Nutrition

1. Megavitamin and nutrition based therapy.
2. Nutritional counseling for either individuals or groups.
3. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

## J. Physical Appearance

1. Cosmetic Procedures. See the definition in (Section 10: Glossary of Defined Terms.) Examples include:
  - Pharmacological regimens, nutritional procedures or treatments.
  - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
  - Skin abrasion procedures performed as a treatment for acne.

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2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.
 

**Note:** Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in (Section 1: What's Covered--Benefits).
3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
5. Wigs regardless of the reason for the hair loss.

## K. Providers

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

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## L. Reproduction

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

## 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 1: What's Covered--Benefits).
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan.)
3. Health services for transplants involving mechanical or animal organs.

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4. Any solid organ transplant that is performed as a treatment for cancer.
5. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Health Services* in (Section 1: What's Covered--Benefits).

## O. Travel

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

## P. Vision and Hearing

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

## Q. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in (Section 10: Glossary of Defined Terms).
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
  - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.

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- Related to judicial or administrative proceedings or orders.
  - Conducted for purposes of medical research.
  - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
  4. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
  5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
  6. In the event that a non-Network provider waives Copayments for a particular health service, no Benefits are provided for the health service for which the Copayments 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 medical or dental in nature.
  9. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.
  10. Surgical and non-surgical treatment of obesity, including morbid obesity.
  11. Growth hormone therapy.
  12. Sex transformation operations.
  13. Custodial Care.
  14. Domiciliary care.
  15. Private duty nursing.
  16. Respite care.
  17. Rest cures.
  18. Psychosurgery.
  19. Treatment of benign gynecomastia (abnormal breast enlargement in males).
  20. Medical and surgical treatment of excessive sweating (hyperhidrosis).
  21. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
  22. Oral appliances for snoring.
  23. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly.
  24. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
  25. Any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply or equipment.
  26. Any charge for services, supplies or equipment advertised by the provider as free.
  27. Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency.
  28. Any charges prohibited by federal anti-kickback or self-referral statutes.
  29. Any additional charges submitted after payment has been made and your account balance is zero.
  30. Any outpatient facility charge in excess of payable amounts under Medicare.

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31. Any charges by a resident in a teaching hospital where a faculty Physician did not supervise services.

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## Section 3: Obtaining Benefits

This section includes information about:

- Benefits for Covered Health Services.
- Your responsibility for notification.
- Emergency Health Services.

### Benefits for Covered Health Services

Benefits are payable for Covered Health Services that are provided by or under the direction of a Physician or other provider.

#### *If You Obtain Services from a Network Provider*

The Claims Administrator arranges for health care providers to participate in a Network. These Network providers have agreed to discount their charges for Covered Health Services. You can find a list of Network providers by logging onto [myuhc.com](http://myuhc.com).

If you use a Network provider, your Copayment amount will generally be less than it would be if you use a non-Network provider. The Copayment level will remain the same, but because the total amount of Eligible Expenses may be less when you use a Network provider, the portion that you owe will be less.

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

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

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

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients.

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

#### *Designated Facilities and Other Providers*

If you have a medical condition that the Claims Administrator believes needs special services, they may direct you to a Designated Facility or other provider chosen by them.

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

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## Your Responsibility for Notification

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

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

### **Care Coordination**<sup>SM</sup>

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

## Emergency Health Services

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

- If you are confined in a Hospital after you receive Emergency Health Services, the Claims Administrator must be notified within one business day or on the same day of admission if reasonably possible.
- If you are admitted as an inpatient to a 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 will apply instead.

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

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## Section 4: When Coverage Begins

This section includes information about:

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

### How to Enroll

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

### If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services related to that

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

### If You Are Eligible for Medicare

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

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

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## Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
<b>Eligible Person</b>	<p>Eligible Person usually refers to an employee of ours who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Participant. For a complete definition of Eligible Person and Participant, see (Section 10: Glossary of Defined Terms).</p> <p>If both spouses are Eligible Persons under the Plan, each may enroll as a Participant or be covered as an Enrolled Dependent of the other, but not both.</p> <p>Except as we have described in (Section 4: When Coverage Begins), Eligible Persons may not enroll without our written permission.</p>	<p>We determine who is eligible to enroll under the Plan.</p>
<b>Dependent</b>	<p>Dependent generally refers to the Participant's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see (Section 10: Glossary of Defined Terms).</p> <p>Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan.</p> <p>If both parents of a Dependent child are enrolled as a Participant, only one parent may enroll the child as a Dependent.</p> <p>Except as we have described in (Section 4: When Coverage Begins), Dependents may not enroll without our written permission.</p>	<p>We determine who qualifies as a Dependent.</p>

# When to Enroll and When Coverage Begins

When to Enroll	Who Can Enroll	Begin Date
<p><b>Initial Enrollment Period</b></p> <p>The Initial Enrollment Period is the first period of time when Eligible Persons can enroll.</p>	<p>Eligible Persons may enroll themselves and their Dependents.</p>	<p>Coverage begins on the date identified by the Plan Administrator, if the Plan Administrator receives the completed enrollment form and any required contribution for coverage within 31 days of the date the Eligible Person becomes eligible to enroll.</p>
<p><b>Open Enrollment Period</b></p>	<p>Eligible Persons may enroll themselves and their Dependents.</p>	<p>The Plan Administrator determines the Open Enrollment Period. Coverage begins on the date identified by the Plan Administrator if the Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the date the Eligible Person becomes eligible to enroll.</p>
<p><b>New Eligible Persons</b></p>	<p>New Eligible Persons may enroll themselves and their Dependents.</p>	<p>Coverage begins on the first day of the month following the date of hire if the Plan Administrator receives the properly completed enrollment form and any required contribution for coverage within 31 days of the date the new Eligible Person becomes eligible to enroll and if the Participant pays any required contribution to the Plan Administrator for Coverage.</p>

## Adding New Dependents

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

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

Coverage begins on the date of the event if the Plan Administrator received the completed enrollment form and any required contribution for coverage within 31 days of the event that makes the new Dependent eligible.

## Special Enrollment Period

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

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

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

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

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

**Event Takes Place** (for example, a birth, marriage or determination of eligibility for state subsidy). Unless otherwise noted under the “Who Can Enroll” column, coverage begins on the date of the event if the Plan Administrator receives the completed enrollment information and any required contribution within 31 days of the event.

**Missed Initial Enrollment Period or Open Enrollment Period.** Unless otherwise noted under the “Who Can Enroll” column, coverage begins on the day immediately following the day coverage under the prior plan ends if the Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the date coverage under the prior plan ended.

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

- Coverage under the prior plan ended because of any of the following:
    - Loss of eligibility (including, without limitation, legal separation, divorce or death).
    - The employer stopped paying the contributions.
    - In the case of COBRA continuation coverage, the coverage ended.
    - The Eligible Person previously declined coverage under the Plan, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP (you must notify the Plan Administrator within 60 days of determination of subsidy eligibility).
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## Section 5: How to File a Claim

This section provides you with information about:

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

### If You Receive Covered Health Services from a Network Provider

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

### Filing a Claim for Benefits

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

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

If a Participant provides written authorization to allow direct payment to a provider, 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. We 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 us, you must provide us with all of the following information:

- A. A Participant's name and address.
- B. The patient's name, age and relationship to the Participant.
- C. The member number stated on your ID card.
- D. An itemized bill from your provider that includes the following:
  - Patient Diagnosis
  - Date(s) of service
  - Procedure Code(s) and descriptions of service(s) rendered
  - Charge for each service rendered
  - Provider of service Name, Address and Tax Identification Number
- E. The date the Injury or Sickness began.

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

### ***Payment of Benefits***

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

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

### ***Benefit Determinations***

#### ***Post-Service Claims***

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

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

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

#### ***Pre-Service Claims***

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

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

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of your medical condition could cause severe pain. In these situations:

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

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

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

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

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

### *Concurrent Care Claims*

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim as defined above, your

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

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

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# Section 6: Questions and Appeals

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

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

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

## What to Do First

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

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

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

## How to Appeal a Claim Decision

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

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

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

## Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims

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Administrator 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 decision on your appeal as follows:

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

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

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 of the Claims Administrator, you have the right to request a second level appeal from the Claims Administrator. Your second level appeal

request must be submitted to the Claims Administrator in writing within 60 days from receipt of the first level appeal decision.

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

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

## Urgent Claim Appeals that Require Immediate Action

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

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

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

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# Section 7: Coordination of Benefits

This section provides you with information about:

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

## Benefits When You Have Coverage under More than One Plan

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

## When Coordination of Benefits Applies

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

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

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

## Definitions

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

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

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

usual and customary fees for a specific benefit is not an Allowable Expense.

- c. If a person is covered by two or more Coverage Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
  - d. If a person is covered by one Coverage Plan that calculates its benefits or services on the basis of usual and customary fees and another Coverage Plan that provides its benefits or services on the basis of negotiated fees, the Primary Coverage Plan's payment arrangements shall be the Allowable Expense for all Coverage Plans.
  - e. The amount a benefit is reduced by the Primary Coverage Plan because a Covered Person does not comply with the Coverage Plan provisions. Examples of these provisions are 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.

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## Order of Benefit Determination Rules

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

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

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the Coverage Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Coverage Plan is primary.

2. Child Covered Under More Than One Coverage Plan. The order of benefits when a child is covered by more than one Coverage Plan is:
  - a. The Primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:
    - 1) The parents are married;
    - 2) The parents are not separated (whether or not they ever have been married); or
    - 3) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.
  - b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or plan years commencing after the Coverage Plan is given notice of the court decree.
  - c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
    - 1) The Coverage Plan of the custodial parent;
    - 2) The Coverage Plan of the spouse of the custodial parent;

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

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

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

## **Effect on the Benefits of this Plan**

- A. When this Coverage Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Coverage Plans during a claim determination period are not more than 100 percent of total Allowable Expenses. The difference between the benefit payments that this Coverage Plan would have paid had it been the Primary Coverage Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the Covered Person and used by this Coverage Plan to pay any Allowable Expenses, not otherwise paid during the claim determination period. As each claim is submitted, this Coverage Plan will:
  1. Determine its obligation to pay or provide benefits under its contract;
  2. Determine whether a benefit reserve has been recorded for the Covered Person; and
  3. Determine whether there are any unpaid Allowable Expenses during that 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 claims determination period. At the end of the claim determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.
- B. If a Covered Person is enrolled in two or more closed panel Coverage Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one

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closed panel Coverage Plan, COB shall not apply between that Coverage Plan and other closed panel Coverage Plans.

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

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

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

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## **Right to Receive and Release Needed Information**

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

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

## **Payments Made**

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

## **Right of Recovery**

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or

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any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

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## Section 8: When Coverage Ends

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

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

### General Information about When Coverage Ends

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

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

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

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

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## Events Ending Your Coverage

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

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

## Other Events Ending Your Coverage

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

Ending Event	What Happens
<b>Fraud, Misrepresentation or False Information</b>	You commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent.
<b>Threatening Behavior</b>	You commit an act of physical or verbal abuse that imposes a threat to the Plan's staff, UnitedHealthcare's staff, a provider or another Covered Person.

## Coverage for a Handicapped Child

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

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

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

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

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

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

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## Extended Coverage for Total Disability

Coverage for a Covered Person who is Totally Disabled on the date the Participant's coverage under the Plan ends will not end automatically. We will temporarily extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.
- Three months from the date coverage would have ended when the entire Plan was terminated.

## Continuation of Coverage

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

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

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

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## Continuation Coverage under Federal Law (COBRA)

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

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

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

## Qualifying Events for Continuation Coverage under Federal Law (COBRA)

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

- A. Termination of the Participant from employment with us, for any reason other than gross misconduct, or reduction of hours;  
or
- B. Death of the Participant; or

- C. Divorce or legal separation of the Participant; or
- D. Loss of eligibility by an Enrolled Dependent who is a child; or
- E. Entitlement of the Participant to Medicare benefits; or
- F. The Plan Sponsor filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Participant and his or her Enrolled Dependents. This is also a qualifying event for any retired Participant and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

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

The Participant or other Qualified Beneficiary must notify the Plan Administrator within 60 days of the Participant's divorce, legal separation or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent. If the Participant or other Qualified Beneficiary fails to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Participant is continuing coverage under Federal Law, the Participant must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Continuation must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the Plan Administrator.

If the Qualified Beneficiary's coverage was terminated due to a qualifying event, then the initial premium due to the Plan

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Administrator must be paid on or before the 45th day after electing continuation.

## Terminating Events for Continuation Coverage under Federal Law (COBRA)

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

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

If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at anytime within the first 60 days of continuation coverage for qualifying event A. then the Qualified Beneficiary may elect an additional 11 months of continuation coverage (for a total of 29 months of continued coverage) subject to the following condition: (i) notice of such disability must be provided within 60 days after the determination of the disability, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

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- B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Participant, divorce or legal separation of the Participant, loss of eligibility by an Enrolled Dependent who is a child (i.e. qualifying events B., C., or D.).
- C. For the Enrolled Dependents of a Participant who was entitled to Medicare prior to a qualifying event that was due to either the termination of employment or work hours being reduced, eighteen months from the date of the qualifying event, or, if later, 36 months from the date of the Participant's Medicare entitlement.
- D. The date coverage terminates under the Plan for failure to make timely payment of the premium.
- E. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any preexisting condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.
- F. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event F.).
- G. The date the entire Plan ends.
- H. The date coverage would otherwise terminate under the Plan as described in this section under the heading *Events Ending Your Coverage*.

If a Qualified Beneficiary is entitled to 18 months of continuation and a second qualifying event occurs during that time, the Qualified

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Beneficiary's coverage may be extended up to a maximum of 36 months from the date coverage ended because employment was terminated or hours were reduced. If the Qualified Beneficiary was entitled to continuation because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event F.) and the retired Participant dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for 36 months from the date of the Participant's death. Terminating events B. through G. described in this section will apply during the extended continuation period.

Continuation coverage for Qualified Beneficiaries whose continuation coverage terminates because the Participant becomes entitled to Medicare may be extended for an additional period of time. Such Qualified Beneficiaries should contact the Plan Administrator for information regarding the continuation period.

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# Section 9: General Legal Provisions

This section provides you with information about:

- General legal provisions concerning your Plan.

## Plan Document

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

This Summary Plan Description is not a contract of employment.

## Relationship with Providers

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

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

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

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

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

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

## Your Relationship with Providers

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

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

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

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## Incentives to Providers

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

Examples of financial incentives for Network providers are:

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

The methods used to pay specific Network providers may vary. From time to time, the payment method may change. If you have questions about whether your Network provider's contract includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact the Claims Administrator at the telephone number on your ID card. They can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

## Incentives to You

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

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about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact the Claims Administrator if you have any questions.

## Interpretation of Benefits

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

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

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

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

## Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior

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notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

## Amendments to the Plan

We reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Plan. Plan Amendments and Riders are effective on the date we specify.

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

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

## Clerical Error

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

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## Information and Records

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

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

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

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

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

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

## Examination of Covered Persons

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

## Workers' Compensation not Affected

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

## Medicare Eligibility

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

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

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you must enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll

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and maintain that coverage, and if we are the secondary payer as described in (Section 7: Coordination of Benefits), we will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

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

## Subrogation

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

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

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## Right to Reimbursement

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

## Third Parties

The following persons and entities are considered third parties:

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

## Subrogation and Reimbursement Provisions

As a Covered Person, you agree to the following:

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- You will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - complying with the terms of this section;
  - providing any relevant information requested;
  - signing and/or delivering documents at its request;

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- notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
  - responding to requests for information about any accident or injuries;
  - appearing at medical examinations and legal proceedings, such as depositions or hearings; and
  - obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.
- If you receive payment as part of a settlement or judgment from any third party as a result of a Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
  - If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.
  - You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
  - Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a Sickness or Injury caused by a third party.
  - The Plan's rights will not be reduced due to your own negligence.
  - The Plan may, at its option, take necessary and appropriate action to assert its rights under this section, including filing suit in your name, which does not obligate it in any way to pay you part of any recovery the Plan might obtain.

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- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- Your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.
- If a third party causes you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Covered Person.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

## **Limitation of Action**

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

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

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lose any rights to bring such an action against us or the Claims Administrator.

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# Section 10: Glossary of Defined Terms

This section:

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

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

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

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

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

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**Autism Spectrum Disorders** - a group of neurobiological disorders that includes *Autistic Disorder, Rett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder, and Pervasive Development Disorders Not Otherwise Specified (PDDNOS)*.

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

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

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

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

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

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

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

**Covered Person** - either the Participant or an Enrolled Dependent, but this term applies only while the person is enrolled under the

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Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

**Custodial Care** - services that:

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

**Dependent** - the Subscriber's legal spouse or a dependent child of the Subscriber or the Subscriber's spouse who is under age 26. All references to the spouse of a Subscriber shall include a Domestic Partner. The term child includes any of the following:

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

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order. We are responsible for determining if

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an order meets the criteria of a Qualified Medical Child Support Order.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

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

**Durable Medical Equipment** - medical equipment 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 amount we will pay for Covered Health Services, incurred while the Plan is in effect, are determined as stated below:

Eligible Expenses are based on either of the following:

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- When Covered Health Services are received from Network providers, Eligible Expenses are the contracted fee(s) with that provider.
- When Covered Health Services are received from non-Network providers, the Claims Administrator calculates Eligible Expenses based on available data resources of competitive fees in that geographic area, unless you received services as a result of an Emergency or as otherwise arranged through the Claims Administrator. In this case, Eligible Expenses are the fee(s) that are negotiated with the non-Network provider.

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

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

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

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

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

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

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

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

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

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

**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 determined by the Plan Administrator, during which Eligible Persons may enroll themselves and their Dependents under the Plan.

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

**Inpatient Rehabilitation Facility** - a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility)

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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.

**Intensive Outpatient Treatment** - a structured outpatient Mental Health or Substance Use Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

**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.

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

**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 Plan.

**Network** - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect with the Claims Administrator or an affiliate (directly or through one

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or more other organizations) to provide Covered Health Services to Covered Persons.

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

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

**Open Enrollment Period** - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Plan. We and the Plan Administrator will agree upon the period of time that is the Open Enrollment Period.

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

**Partial Hospitalization/Day Treatment** - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

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

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

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Benefits for services from that provider are available to you under the Plan.

**Plan** - PPO Medicare Supplemental Plan for Washington Suburban Sanitary Commission Health Benefit Plan.

**Plan Administrator** - is Washington Suburban Sanitary Commission or its designee.

Washington Suburban Sanitary Commission  
14501 Sweitzer Lane, 6th Floor  
Laurel, MD 20707-5902

Phone number: (301) 206-8691

EIN number: 52-6002653

**Plan Sponsor** - Washington Suburban Sanitary Commission. References to "we", "us", and "our" throughout the SPD refer to the Plan Sponsor.

**Pregnancy** - includes all of the following:

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

**Residential Treatment Facility** - a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs;

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- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee;
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- It provides at least the following basic services in a 24-hour per day, structured milieu:
  - Room and board;
  - Evaluation and diagnosis;
  - Counseling; and
  - Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

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

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

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

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

**Specialist Physician** - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. For Mental Health Services and Substance Use Disorder Services, any licensed clinician is considered on the same basis as a Specialist Physician.

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

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

**Transitional Care** - Mental Health Services/Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

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- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangement which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

**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.

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

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

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# Riders, Amendments, Notices

Attachment I

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# Attachment

## I

### Patient Protection and Affordable Care Act (“PPACA”)

#### *Grandfathered Health Plan Notice*

This group health plan believes this Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the U.S.

Department of Health and Human Services at [www.healthreform.gov](http://www.healthreform.gov).

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### Women's Health and Cancer Rights Act of 1998

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

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

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

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

### 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

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

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