Travis County Commissioners Court Agenda Request

Meeting Date: October 9, 2012, Voting Session
Prepared By: John Rabb, HRMD, 854-2472
Elected/Appointed Official/Dept. Head: Diane Poirot, HR Director 854-9165
Leslie Browder, County Executive-PBO 854-8679
Sponsors: Judge Biscoe

AGENDA LANGUAGE:

Consider and take appropriate action on the Summary Plan Descriptions for Travis County Healthcare Plans for Fiscal Years 2010 through 2013.

BACKGROUND/SUMMARY OF REQUEST AND ATTACHMENTS:

The Travis County Employee and Retiree health plans are self-funded plans, for which the County contracts with Unitedhealthcare (UHC) for Third Party Administration services. As part of this administration service the plans must have written Summary Plan Descriptions (SPD's) so UHC knows how to administer the plan, and the plan participants have written information on what benefits are covered or not covered, and how those services will be considered at time of claim. These SPD's provide valuable information to members of the plan regarding the benefits of the plan, and any requirements or exclusions that they need to be aware of to fully understand their benefits. A few examples of what might be included in an SPD are shown below:

- A description of the benefits included in the plan that is written in understandable language,
- A listing of any excluded services, or services requiring a special procedure, such as a transplant,
- Co-payments or co-insurance amounts the covered persons may be responsible for paying (including when copays and co-insurance apply),
- the legal aspects of the plan including the appeals process, COBRA, and the co-ordination of benefits with other responsible plans,

Each year Commissioners Court has considered, and often implemented, changes to the benefits and the contribution to each of the plans. However, these have not been fully documented in SPDs approved by the court since 2005. With the legal changes implemented by the federal Affordable Care Act, it would be advantageous to formally document the details of each plan in the last year before this act was effective for reference in case of subrogation or other legal actions. In addition, it is important to record the changes made and when they were made over the last two years because some of these are significant.

Despite the name, these descriptions are lengthy, averaging over 150 pages each. In the past, there have been separate SPDs for

- Choice Plus Preferred Provider Organization (PPO),
- Choice Exclusive Provider Organization (EPO), and
- Co-insured Choice Exclusive Provider Organization (CEPO).

Therefore, we are bringing SPDs related to several years to you for approval at this time. We have combined the plans for actives and retirees into one SPD for each Plan, as some provisions differ for actives and retirees.
While technically 6 plans (3 for active, and 3 for retirees) these are combined into 3 SPD's for Fiscal Year 2010 (FY 10) and into 1 SPD for FY 11 and after. The first set of SPD's follows the format used in 2005 when the last SPDs were approved.

The FY11- FY12 SPD and the FY13 SPD use a new user friendly format and have consolidated all plans into one document because the benefit descriptions and legal aspects of the plans which represent about 90% of each plan are the same for all plans. The plans differ in relation eligibility, enrollment options, and the applicable contributions that a covered person must pay.

The FY 13 SPD incorporated the changes that have been made in the plan in the last two years into the main document so that it will be clearer and easier for employees to use. In addition, all of the most recent federal heatthcare reform mandates that are applicable have been included. Staff is looking forward to being able to place the FY 13 SPD on the intranet for easy access for most employees.

The SPDs attachments include:

For Fiscal Year 2010:
Combined Summary Plan Description for

- Choice Plus Plan for Travis County Employees and
- Choice Plus Plan for Travis County Retirees

Combined Summary Plan Description for

- Choice Plan for Travis County Employees and
- Choice Plan for Travis County Retirees

Combined Summary Plan Description for

- Co-Insured Choice Plan for Travis County Employees and
- Co-Insured Choice Plan for Travis County Retirees

For Fiscal Years 2011 and 2012:
Combined Summary Plans Description

- Choice Plus Plan for Employees,
- Choice Plus Plan for Retirees,
- Choice Plan for Employees,
- Choice Plan for Retirees
- Co-Insured Choice Plan for Employees, and
- Co-Insured Choice Plan for Retirees

For Fiscal Years 2013:

Combine Summary Plans Description

- Choice Plus Plan for Employees,
- Choice Plus Plan for Retirees,
- Choice Plan for Employees,
- Choice Plan for Retirees
- Co-Insured Choice Plan for Employees, and
- Co-Insured Choice Plan for Retirees

STAFF RECOMMENDATIONS:

Consider and take appropriate action on the Summary Plan Descriptions for Travis County Healthcare Plans for Fiscal Years 2010 through 2013.

Staff Recommends approval of the Summary Plan Descriptions for Travis County Healthcare Plans for Fiscal Year 2010 through 2013

ISSUES AND OPPORTUNITIES:

Staff is pleased to be able provide current SPD's to employees and retirees that contain the latest in healthcare reform provisions. It is also a compliance issue, as health plans are required to make Summary Plan Descriptions available. Our plan is to load these on Travis Central for ease of access by employee and also load on external site for use by retirees. . A printed copy may be made by accessing online, or if needed, contact HRMD and a printed copy will be provided.

FISCAL IMPACT AND SOURCE OF FUNDING:

There is no fiscal impact to Travis County. The Summary Plan Descriptions were prepared as part of the administrative services provided by United Healthcare and internal Travis County resources.

REQUIRED AUTHORIZATIONS:

Human Resources Management	Diane Poirot
Human Resources Management	John Rabb
Human Resources Management	Cindy Purinton/Shannon Steele
Planning and Budget Office	Leslie Browder
County Judge's Office	Cheryl Aker
Commissioners Court	Gillian Porter

TRAVIS COUNTY

Summary Plan Description

Choice Plus Plan for Retirees,

Choice Plus Plan for Employees,

EPO Choice Plan for Employees,

EPO Choice Plan for Retirees

Coinsured Choice Plan for Employees

Coinsured Choice Plan for Retirees, the Travis County Health Benefit Plan

Effective: October 1, 2012
Group Number: 701254

UnitedHealthcare®
A UnitedHealth Group Company

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SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance Use Disorder Administrator: 1-866-649-4873;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 30555, Salt Lake City, Utah 84130-0555; and
- Online assistance: **www.myuhc.com**.

Travis County is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members. It includes summaries of:

- who is eligible;
- what you have to contribute to costs of services that are covered,
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

This SPD is designed to meet your information needs. It supersedes any previous printed or electronic SPD for this Plan.

Note: This SPD is a combined description for multiple plans. The SPD describes the benefits offered in the following plans: Choice Plus Plan for Employees, Choice Plus Plan for Retirees, Choice Plan for Employees, Choice Plan for Retirees, CoInsured Plan for Employees and CoInsured Plan for Retirees. Please read this SPD thoroughly to learn how the Travis County Health Benefit Plans work. Please reference the sections that pertain to the Benefits in the Plan that you have chosen. If you have questions contact your local Human Resources Management Department or call the number on the back of your ID card.

Travis County intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice.

This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps Travis County to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. Travis County is solely responsible for paying Benefits described in this SPD.

How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can obtain copies of your SPD and any future amendments by contacting the Human Resources Management Department.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Member as defined in Section 14, *Glossary*.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plans;
- The factors that impact your cost for coverage;
- Instructions and timeframes for enrolling yourself and your eligible dependents;
- When coverage begins; and
- When you can make coverage changes under the Plans.

Eligibility

Plans for Employees

You are eligible to enroll in the Plan if you are a regular employee who is scheduled to work at least 20 hours per week. To be eligible for coverage under the Plan, a Member must reside within the United States.

Your eligible dependents may also participate in the Plan.

Plans for Retirees

You are eligible to enroll in the Plan if you are a person who:

- is terminated or retired from Travis County
- is receiving annuity benefits from the Texas County and District Retirement Association due to employment with Travis County, and
- either
  - retires while covered under one of the Employee Plans and maintains coverage continuously under one of the Retiree Plans after retirement or
  - has been covered under one of the Retiree Plans continuously since October 1, 2005.

To be eligible for coverage under the Plan, a Member must reside within the United States.

Your eligible dependents may also participate in the Plan if you were covering them on an Employee Plan just before your retired and continued coverage for them under one of the Retiree Plans when You retired and have maintained coverage continuously for them after Your retirement or You have covered them continuously as Your dependents while You were a retiree since October 1, 2005.

Dependents

An eligible dependent is considered to be:

- your Spouse, Sponsored Dependent, or Domestic Partner as defined in Section 14, Glossary;

- your child who is under age 26, including:
  - a natural child,
  - a stepchild,
  - a legally adopted child in the Member's home,
  - a child placed in the Member's home for adoption,
  - a child for whom you are the legal guardian,
  - a grandchild for whom you are the legal guardian,
  - any other child related to the Member who is mainly dependent on the Member for care and support and who is residing in the Member's home and for whom a completed guardianship document has been obtained,
  - an unmarried child age 26 or over who is or becomes disabled and is dependent upon you if the child complies with the continuation requirements in Section 12, *When Coverage Ends*, or
  - a child for whom you are required to provide health care coverage through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*;

and either

- your Spouse's child who is under age 26, including:
  - a natural child,
  - a stepchild who resides in the Member's home,
  - a legally adopted child in the Member's home,
  - a child placed in the Member's home for adoption,
  - a child for whom your Spouse is the legal guardian,
  - a grandchild for whom your Spouse is the legal guardian,
  - any other child related to your Spouse who is mainly dependent on the Member for care and support and who is residing in the Member's home and for whom a completed guardianship document has been obtained,
  - an unmarried child age 26 or over who is or becomes disabled and is dependent upon you if the child complies with the continuation requirements in Section 12, *When Coverage Ends*, or
  - a child for whom your Spouse is required to provide health care coverage *through* a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*;

or

- your Domestic Partner's child who is under age 26, including:
  - a natural child,
  - a stepchild who resides in the Member's home,
  - a legally adopted child in the Member's home,
  - a child placed in the Member's home for adoption,
  - a child for whom your Domestic Partner is the legal guardian,
  - a grandchild for whom your Domestic Partner is the legal guardian,

- any other child related to the Domestic Partner who is mainly dependent on the Member for care and support and who is residing in the Member's home and for whom a completed guardianship document has been obtained,
- an unmarried child age 26 or over who is or becomes disabled and is dependent upon you if the child complies with the continuation requirements in Section 12, When Coverage Ends, or
- a child for whom your Domestic Partner is required to provide health care coverage through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, Other Important Information.

To be eligible for coverage under the Plan, a dependent must reside within the United States.

Note: Your dependents may not enroll in the Plan unless you are also enrolled. Anyone eligible as an employee or retiree may not enroll as a dependent. In addition, if you and your Spouse or Domestic Partner are both covered under the Travis County Employee Health Benefit Plan, only one parent may enroll your child as a dependent. No one can be a dependent of more than one Member.

Cost of Coverage

Plans for Employees

You and Travis County share in the cost of the Plan. Your contribution is the amount set by the Commissioners Court each year. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks. You may select to have them deducted on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld - and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you. If you select to have your contributions deducted on a before tax basis, you can only change your coverage at Open Enrollment unless a change in family status occurs.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children eligible dependents for income tax purposes. Therefore, the value of Travis County's cost in covering a Domestic Partner may be imputed to the Member as income. In addition, the share of the Member's contribution that covers a Domestic Partner and the Domestic Partner's children must be paid using after-tax payroll deductions.

Your contributions are subject to review and Travis County reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling the Human Resources Management Department.

Plans for Retirees

If You were employed by Travis County for eight years or more before You retired, You and Travis County may share in the cost of the Plan if the Commissioners Court approves a county contribution to the actuarially determined contribution for the applicable plan year. If no county contribution is approved, You must pay the entire actuarially determined contribution. Your contribution is the amount set by the Commissioners Court each year. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

If You have not been an employee of Travis County for eight years before You retire, You must pay the entire actuarially determined contribution and Travis County will not share in the cost of the Plan. Your contribution is the amount set by the Commissioners Court each year. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

You are invoiced for your contributions and must pay them directly to the invoicing service.

Your contributions are subject to review and Travis County reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling the Human Resources Management Department.

How to Enroll

Plans for Employees

To enroll, call the Human Resources Management Department within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next Open Enrollment to make your Benefit elections.

Each year during Open Enrollment, you have the opportunity to review and change your medical Plan election. Any changes you make during Open Enrollment will become effective the following October 1.

Important
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact the Human Resources Management Department within 31 days of the event. Otherwise, you will need to wait until the next Open Enrollment to change your elections.

Plans for Retirees

To enroll, call the Human Resources Management Department within 30 days before the date you plan to retire. If You do not enroll before the date you retire, You will not be able to enroll later.

If You are covered when You retire and continuously maintain Your coverage or were retired and have continuously maintained Your coverage since October 1, 2005, each year during Annual Enrollment, You have the opportunity to enroll to continue coverage under a

Retiree medical Plan for Yourself and any dependents for whom You have continuously maintained coverage since Your retirement or, if retired on October 1, 2005, You have continuously maintained their coverage since October 1, 2005. In addition, You may select this coverage from the Choice Plus Plan for Retirees, the EPO Choice Plan for Retirees or the Coinsured Choice Plan for Retirees. You may also elect to discontinue this coverage for Yourself or Your dependents for the rest of Your life or their lives. Any changes You make during Annual Enrollment will become effective the following October 1.

When Coverage Begins

Plans for Employees

Once the Human Resources Management Department receives your properly completed enrollment, coverage will begin on the first day of the month after the end of a 30 day waiting period. Coverage for your dependents will start on the date your coverage begins, if you have enrolled them in a timely manner.

Coverage for a Spouse or dependent stepchild that you acquire through marriage becomes effective the first of the month after the date the Human Resources Management Department receives notice of your marriage, if you notify the Human Resources Management Department within 31 days after your marriage.

Coverage for dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, if you notify the Human Resources Management Department within 31 days after the birth, adoption, or placement.

Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Plans for Retirees

Once the Human Resources Management Department receives your properly completed enrollment, coverage will begin on the first day of your retirement. Coverage for your dependents will start on the date your coverage begins, if you have enrolled them in a timely manner.

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, the Plan will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify UnitedHealthcare within 48 hours of the day your coverage begins, or as soon as is reasonably possible.

Changing Your Coverage

Plans for Employees

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you can cover your Spouse following your marriage, your child following an adoption, but not your Spouse following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- your acquisition of a Domestic Partner;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- a loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a dependent;
- your dependent child no longer qualifying as an eligible dependent;
- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage;
- a significant or material change in the contributions or Plan design of the employee or Covered Dependent coverage;
- you or your eligible dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible dependent;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible dependent;
- termination of your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact the Human Resources Management Department within 60 days of termination);
- you or your dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact the Human Resources Management Department within 60 days of determination of subsidy eligibility);
- a strike or lockout involving you or your Spouse; or
- a court or administrative order.

Unless otherwise noted in the list above, if you wish to change your Benefit elections, you must contact the Human Resources Management Department within 31 days of the change in family status. Otherwise, you must wait until the next Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible dependent if COBRA is elected.

Change in Family Status - Example

Jane is married and has two children who qualify as dependents. At Open Enrollment, she elects not to participate in Travis County's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under Travis County's medical plan outside of Open Enrollment if she contacts Human Resources Management Department within 31 days of Tom's last day of medical coverage.

Plans for Retirees

Retirees may not make changes in their coverage during the year. If a Retiree fails to pay the applicable monthly contribution for the coverage elected, after the grace period and notice of failure to pay, their coverage will be terminated. If your coverage is terminated, you will not be eligible to enroll at any subsequent Annual Enrollment.

SECTION 3A - HOW THE CHOICE PLUS PLAN WORKS

What this section includes:

- Network and Non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Coinsurance; and
- Out-of-Pocket Maximum.

Network and Non-Network Benefits

As a Member in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and whether any benefit limitations may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Network Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services. When you receive Covered Health Services at a Network facility, you are eligible for the Network level of Benefits when Covered Health Services are provided under the primary direction of a Network Physician or other provider. Some services at a Network facility may be provided by Non-Network providers because these providers are associated with the Network facility. These services might include Physician services provided by a Non-Network anesthesiologist, Emergency room Physician, consulting Physician on the initial visit, pathologist or radiologist. Services by these providers are covered at the Network level because the primary direction is provided by a Network Physician and services are provided at a Network facility.

Emergency Room Health Services received at a Non-Network Hospital are covered at the Network level.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a Non-Network provider.

If you choose to seek care outside the Network, your cost for the services will generally be higher than if you had gone to a Network provider. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the Non-Network provider about their billed charges before you receive care.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. Network providers are independent practitioners and are not employees of Travis County or UnitedHealthcare.

At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto **www.myuhc.com**.

Looking for a Network Provider?
Use **www.myuhc.com** to search for Physicians available in your Plan.

In addition to other helpful information, **www.myuhc.com**, UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network.

While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information.

Possible Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to coordinate all of your future Covered Health Services. If you do not make a selection within 31 days after the date you are notified, UnitedHealthcare will select a Network Physician for you. If you do not use that Network Physician to coordinate all of your care, any Covered Health Services you receive will be paid at the Non-Network level.

Eligible Expenses

Eligible Expenses are charges for Covered Health Services that are provided while the Plan is in effect, determined according to the definition for Eligible Expenses for Choice Plus Plan in Section 14, *Glossary*.

For certain Covered Health Services, the Plan will not pay the expenses until you have met your Annual Deductible. UnitedHealthcare has the initial discretion to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and covered under the Plan.

For certain Covered Health Services, you are required to pay a percentage of Eligible Expenses in the form of a Copay and/or Coinsurance. Eligible Expenses are subject to UnitedHealthcare's reimbursement policy guidelines. You may request a copy of the guidelines related to your claim from UnitedHealthcare.

Don't Forget Your ID Card
Remember to show your UnitedHealthcare ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits to which the Annual Deductible applies. There are separate Network and Non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate during the calendar year. The Annual Deductible is shown in the first table in Section 5, *Plan Highlights*.

When your Benefit is limited to a specific number of visits or days, any visits or days you pay for as part of your Annual Deductible reduce the number of visits or days available to you in the remainder of the year.

Medical expenses are incurred on the date that you receive the Covered Health Service. If you incur medical expenses in the last three months of any given calendar year and these medical expenses are applied to your Deductible for that year, these medical expenses will also be applied to your Deductible in the next year.

If you are covering dependents, your family deductible is determined individually for the group. Medical expenses incurred for a member of your family will be credited to that individual. If a member of your family incurs medical expenses that are credited to your Deductible in the last three months of any given calendar year, those are applied to the medical expenses you incur in the next year. When those combined expenses equal the individual deductible, your deductible for that member of your family is met. If two and one half (2.5) members of your family have met their individual Deductible, based on either medical expenses incurred in the last three months of any given calendar year or in the next year, your family deductible is met, even if one or more other family members have not met their individual Deductible in that year.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is usually a set dollar amount and is paid at the time of service or when billed by the provider. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Copays do not count toward the Out-of-Pocket-Maximum.

Copays do not count toward the Annual Deductible.

Coinsurance

Coinsurance is the amount that you are responsible for paying and is calculated as the percentage of Eligible Expenses. After the Annual Deductible is met, Coinsurance is a fixed percentage that applies to certain Covered Health Services.

Coinsurance – Examples

If you receive Plan Benefits for outpatient surgery from a Network provider and you have not met any of your Annual Deductible, you pay the amount of your individual Annual Deductible, then the Plan pays 90% of the rest of the cost of the surgery, and you are responsible for paying the other 10% of the rest of the cost of the surgery. This 10% is your Coinsurance.

If you receive Plan Benefits for outpatient surgery from a Network provider and you have already met your Annual Deductible, the Plan pays 90%, and you are responsible for paying the other 10%. This 10% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you are required to pay each calendar year for Covered Health Services. There are separate Network and Non-Network Out-of-Pocket Maximums for this Plan. If your eligible Out-of-Pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year unless a Copay applies to the service.

Medical expenses are incurred on the date that you receive the Covered Health Service. If you incur medical expenses in the last three months of any given calendar year, and these medical expenses are applied to the Out-of-Pocket Maximum for that year, these medical expenses will also be applied to the Out-of-Pocket Maximum for the next year.

If you are covering dependents, your family Out-of-Pocket is determined both individually and as a group. Medical expenses incurred for a member of your family are credited to both that individual and the family. If medical expenses are incurred for any member of your family, either in the last three months of any given calendar year or in the next year, and these medical expenses equal the family Out-of Pocket maximum, your family Out-of Pocket maximum is met for the current year, even if no single member of your family has incurred medical expenses sufficient to meet an individual Out-of Pocket maximum.

The following table identifies what does and does not apply toward your Network and Non-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Copays	No	No
Charges for Health Services that are not covered	No	No
The amounts of any reductions in Benefits you incur by not notifying Personal Health Support	No	No
Charges that exceed Eligible Expenses	No	No

How the Plan Works - Example

The following example illustrates how Annual Deductibles, Copays, Out-of-Pocket Maximums and Coinsurance work in practice.

Let's say Gary has individual coverage under the Plan. He has met his Network Annual Deductible, but not his Non-Network Annual Deductible and needs to see a Physician. The flow chart below shows what happens when he visits a Network Physician versus a Non-Network Physician.

Network Benefits
1. Gary goes to see a Network Physician, and presents his ID card.
2. He receives treatment from the Physician. The Plan's Eligible Expense for the Network office visit equals $125.
3. On his way out, Gary pays a $25 Copay. Since Network Physician office visits are covered at 100% after the Copay, Gary has met his financial obligations for this office visit.
4. The Plan pays $100 ($125 Eligible Expense minus $25 Copay).

Non-Network Benefits
1. Gary goes to see a Non-Network Physician, and presents his ID card.
2. He receives treatment from the Physician. The Eligible Expense for his visit is $175, however the Physician's fee is $225.
3. The Physician's office requests no payment, informing Gary that it will bill UnitedHealthcare directly.*
4. Gary is responsible for paying the Eligible Expense of $175 directly to the Physician, because he has not yet met his Annual Deductible.
5. Gary receives a bill from the Physician, and pays the Physician directly.

Network Benefits	Non-Network Benefits
	6. The Physician's office, at its discretion, might bill Gary for the remaining $50:

$225	-	$175	=	$50
(Physician's fee)		(Eligible Expense)		

Gary's $50 payment does not apply to his Annual Deductible or Out-of-Pocket Maximum.
7. UnitedHealthcare applies the $175 toward Gary's Annual Deductible and Out-of-Pocket Maximum.

*Although Non-Network providers have the right to request payment in full at the time of service, they bill UnitedHealthcare directly in most cases.

SECTION 3B - HOW THE CHOICE PLAN AND COINSURED PLAN WORK

What this section includes:

- Network and Non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Coinsurance ; and
- Out-of-Pocket Maximum.

Network and Non-Network Benefits

As a Member in these Plans, you have the freedom to choose the Network Physician or health care professional you prefer each time you need to receive Covered Health Services.

You are eligible for Benefits under these Plans when you receive Covered Health Services from Network Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services. Except as specifically described within the SPD for the Choice Plan and CoInsured Plan, benefits are not available for services provided by a non-Network provider. When you receive Covered Health Services at a Network facility, you are eligible for Benefits when Covered Health Services are provided under the primary direction of a Network Physician or other provider. Some services at a Network facility may be provided by Non-Network providers because these providers are associated with the Network facility. These services might include Physician services provided by a Non-Network anesthesiologist, Emergency room Physician, consulting Physician on the initial visit, pathologist or radiologist. Services by these providers are covered at the Network level because the primary direction is provided by a Network Physician and services are provided at a Network facility.

Members in the Choice Plan or the CoInsured Plan - Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits from a non-Network provider. In this situation, your Network Physician will notify Personal Health Support, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

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

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. Network providers are independent practitioners and are not employees of Travis County or UnitedHealthcare.

At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto **www.myuhc.com**.

Looking for a Network Provider?
Use **www.myuhc.com** to search for Physicians available in your Plan.

In addition to other helpful information, **www.myuhc.com,** UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network.

While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information.

Possible Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a Network Physician for you. In the event that you do not use the Network Physician to coordinate all of your care, any Covered Health Services you receive will not be paid.

Eligible Expenses

Eligible Expenses are charges for Covered Health Services that are provided while the Plan is in effect, determined according to the definition for Eligible Expenses for the Choice and CoInsured Plans in Section 14, *Glossary*.

For certain Covered Health Services, the Plan will not pay these expenses until you have met your Annual Deductible. UnitedHealthcare has the initial discretion to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and covered under the Plan.

For certain Covered Health Services, you are required to pay a percentage of Eligible Expenses in the form of a Copay and/or Coinsurance. Eligible Expenses are subject to UnitedHealthcare's reimbursement policy guidelines. You may request a copy of the guidelines related to your claim from UnitedHealthcare.

Don't Forget Your ID Card
Remember to show your UnitedHealthcare ID card every time you receive health care services from a Network provider. If you do not show your ID card, a Network provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services Expenses before you are eligible to begin receiving Benefits to which the Annual Deductible applies. The amounts you pay toward your Annual Deductible accumulate during the calendar year. The Annual Deductible is shown in the first table in Section 5, *Plan Highlights*.

When a Benefit is subject to a visit or day limit, the balance of the total visits allowed will be reduced by the number of days or visits you use regardless of the Annual Deductible being met or not. Benefits with amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited Benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

Medical expenses are incurred on the date that you receive the Covered Health Service. If you incur medical expenses in the last three months of any given calendar year and these medical expenses are applied to your Deductible for that year, these medical expenses will also be applied to your Deductible in the next year.

If you are covering dependents, your family deductible is determined individually for the group. Medical expenses incurred for a member of your family will be credited to that individual. If a member of your family incurs medical expenses that are credited to your Deductible in the last three months of any given calendar year, those are applied to the medical expenses you incur in the next year. When those combined expenses equal the individual deductible, your deductible for that member of your family is met. If two and one half (2.5) members of your family have met their individual Deductible, based on either medical expenses incurred in the last three months of any given calendar year or in the next year, your family deductible is met, even if one or more other family members have not met their individual Deductible in that year.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is usually a set dollar amount and is paid at the time of service or when billed by the provider. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Copays do not count toward the Out-of-Pocket-Maximum.

Copays do not count toward the Annual Deductible.

Coinsurance

Coinsurance is the amount that you are responsible for paying and is calculated as the percentage of Eligible Expenses. After the Annual Deductible is met, Coinsurance is a fixed percentage that applies to certain Covered Health Services.

Coinsurance – Examples for the Choice Plan

If you are enrolled in the Choice Plan the coinsurance for all benefits is currently zero percent. If you receive Plan Benefits for outpatient surgery from a Network provider and you have not met any of your Annual Deductible, you pay the amount of your individual Annual Deductible, then the Plan pays 100% of the rest of the cost of the surgery, you are responsible for paying the other 0% of the rest of the cost of the surgery. This 0% is your Coinsurance.

If you receive Plan Benefits for outpatient surgery from a Network provider and you have already met your Annual Deductible, the Plan pays 100%, and you are responsible for paying the other 0%. This 0% is your Coinsurance.

Coinsurance – Examples for the CoInsured Plan

If you are enrolled in the CoInsured Plan and you receive Plan Benefits for outpatient surgery from a Network provider and you have not met any of your Annual Deductible, you pay the amount of your individual Annual Deductible, then the Plan pays 80% of the rest of the cost of the surgery, you are responsible for paying the other 20% of the rest of the cost of the surgery. This 20% is your Coinsurance.

If you receive Plan Benefits for outpatient surgery from a Network provider and you have already met your Annual Deductible, the Plan pays 80%, and you are responsible for paying the other 20%. This 20% is your Coinsurance.

Out-of-Pocket Maximum – Choice Plan

There is no Annual Out-of-Pocket Maximum on the Choice Plan.

Out-of-Pocket Maximum – CoInsured Plan

The annual Out-of-Pocket Maximum is the most you are required to pay each calendar year for Covered Health Services. If your eligible Out-of-Pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year unless a Copay applies to the service.

Medical expenses are incurred on the date that you receive the Covered Health Service. If you incur medical expenses in the last three months of any given calendar year, and these medical expenses are applied to the Out-of-Pocket Maximum for that year, these medical expenses will also be applied to the Out-of-Pocket Maximum for the next year.

If you are covering dependents, your family Out-of-Pocket is determined both individually and as a group. Medical expenses incurred for a member of your family are credited to both that individual and the family. If medical expenses are incurred for any member of your family, either in the last three months of any given calendar year or in the next year, and these medical expenses equal the family Out-of Pocket maximum, your family Out-of Pocket maximum is met for the current year, even if no single member of your family has incurred medical expenses sufficient to meet an individual Out-of Pocket maximum.

The following table identifies what does and does not apply toward your Out-of-Pocket Maximum:

Plan Features	Applies to the Out-of-Pocket Maximum?
Payments toward the Annual Deductible	Yes
Coinsurance Payments	Yes
Copays	No
Charges for Health Services that are not covered	No
The amounts of any reductions in Benefits you incur by not notifying Personal Health Support	No
Charges that exceed Eligible Expenses	No

How these Plans Work - Example

The following example illustrates how Annual Deductibles, Copays, Out-of-Pocket Maximums and Coinsurance work in practice.

Let's say Gary has individual coverage under the Plan. He has met his Network Annual Deductible and needs to see a Physician. The flow chart below shows what happens when he visits a Network Physician.

Choice Plan Benefits	CoInsured Plan Benefits
1. Gary goes to see a Network Physician, and presents his ID card.	1. Gary goes to see a Network Physician, and presents his ID card.
|	|
2. He receives treatment from the Physician. The Eligible Expense for the Network office visit equals $130.	2. He receives treatment from the Physician. The Eligible Expense for the Network office visit equals $130.
|	|
3. On his way out, Gary pays a $30 Copay. Since Network Physician office visits are covered at 100% after the Copay, Gary has met his financial obligations for this office visit.	3. On his way out, Gary pays a $20 Copay. Since Network Physician office visits are covered at 100% after the Copay, Gary has met his financial obligations for this office visit.
|	|
4. The Plan pays $100 ($130 Eligible Expense minus $30 Copay).	4. The Plan pays $110 ($130 Eligible Expense minus $20 Copay).

SECTION 4 - PERSONAL HEALTH SUPPORT

What this section includes:
- An overview of the Personal Health Support program; and
- Covered Health Services for which you need to contact Personal Health Support.

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and Cost-Effective services available. A Personal Health Support Nurse is notified when you or your provider calls the toll-free number on your ID card about an upcoming treatment or service.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with a telephone number so you can call with questions about your conditions, or your overall health and well-being. Personal Health Support Nurses provide a variety of different services to help you and your covered Dependents receive appropriate medical care. Program components and notification requirements are subject to change without notice. As of the publication of this SPD, the Personal Health Support program includes:

- **Risk Management** - Designed for Members with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Members may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the Member's specific chronic or complex condition.
- **Admission counseling** - For upcoming inpatient Hospital admissions for certain conditions, a Treatment Decision Support nurse may call you to help answer your questions and to make sure you have the information and support you need for a successful recovery.
- **Inpatient care management** - If you are hospitalized, your Physician will work with a Treatment Decision Support nurse to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Discharge Management and Readmission Avoidance** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will

also share important health care information, answer questions about, repeat, and reinforce discharge instructions, to support a safe transition home for you.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the toll-free number on your ID card.

Requirements for Notifying Personal Health Support

If you are enrolled in the Choice Plus Plan:

Network providers are generally responsible for notifying Personal Health Support before they provide certain services to you. However, there are some Network Benefits for which you are responsible for notifying Personal Health Support.

When you choose to receive certain Covered Health Services from Non-Network providers, you are responsible for notifying Personal Health Support before you receive these Covered Health Services. In many cases, your Non-Network Benefits will be reduced if Personal Health Support is not notified.

The medical services that require Personal Health Support notification are:

- non-emergency air and ground ambulance;
- Congenital Heart Disease services;
- Emergency Room Health Services if you are admitted to a non-Network Hospital;
- dental services - accident only;
- Durable Medical Equipment for items that will cost more than $1,000 to purchase or rent, including equipment for the management and treatment of diabetes;
- home health care;
- hospice care - inpatient;
- Hospital Inpatient Stay, including Emergency admission;
- spinal treatment as described under *Spinal Treatment* in Section 6, *Additional Coverage Details*;
- maternity care that exceeds the delivery timeframes as described in Section 6*, Additional Coverage Details*;
- outpatient dialysis treatments as described in under *Therapeutic Treatments - Outpatient* in Section 6, *Additional Coverage Details*;
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy;
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services; and
- transplantation services.

For notification timeframes, and reductions in Benefits that apply if you do not notify Personal Health Support, see Section 6, *Additional Coverage Details*.

If you are enrolled in the Choice Plan or Coinsured Plan:

In most cases, Network providers are responsible for notifying Personal Health Support before they provide these services to you. However, you are responsible for notifying the Personal Health Support staff prior to receiving a service for:

- dental services - accident only;
- Emergency Room Health Services if you are admitted to a non-Network Hospital;
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy; and
- transplantation services.

For notification timeframes see Section 6, *Additional Coverage Details*. For timeframes and any reductions in Benefits if you do not notify the Mental Health/Substance Use Disorder Administrator, see Section 6, *Additional Coverage Details*.

Contacting Personal Health Support is easy.
Simply call the toll-free number on your ID card.

Special Note About Mental Health and Substance Use Disorder Services

Pre-service notification is required as described below.

Network Benefits (Provider is responsible for notification)

You are not required to provide pre-service notification when you seek these services from Network providers. Network providers are responsible for notifying the Mental Health/Substance Use Disorder Administrator before they provide these services to you.

Non-Network Benefits (Covered Person is responsible for notification)

If you are enrolled in the Choice Plus Plan - When you seek these services from non-Network providers for a scheduled admission, you must notify the Mental Health/Substance Use Disorder Administrator before 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 subject to a $250 penalty.

The following Benefits require notification.

- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility);
- Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders - inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility);

- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility).

If these Benefits are provided by a Network provider, the provider must notify the Mental Health/Substance Use Disorder Administrator. If these Benefits are provided by a Non-Network provider, you must notify the Mental Health/Substance Use Disorder Administrator

Special Note About Medicare

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to notify Personal Health Support before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 10, *Coordination of Benefits (COB)*.

SECTION 5 - PLAN HIGHLIGHTS

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum. See section 6 for a description of the services included as part of the Covered Health Services, limitations on services, and notification requirements that apply to each Covered Health Service.

If you are enrolled in the Choice Plus Plan, a Copay does not apply when you visit a Non-Network provider except for Emergency Room Health Services.

	CHOICE PLUS		EPO CHOICE	COINSURED CHOICE
Plan Features	**Network**	**Non-Network**	**Network**	**Network**
Copays[1]				
■ Ambulance Services	$100	$100	$100	$100
■ Emergency Room Health Services	$125	$125	$125	$125
■ Physician's Office Services - Primary Care Provider	$25	Copay is not applicable, Coinsurance and Deductible apply	$30	$20
■ Physician's Office Services - Specialist	$40	Copay is not applicable, Coinsurance and Deductible apply	$45	$35
■ Rehabilitation Services - Outpatient Therapy	$5 per visit for the first 20 visits after 20 visits a $25 Primary Copay or a $40 Specialist Copay per visit	Copay is not applicable, Coinsurance and Deductible apply	$5 per visit for the first 20 visits; after 20 visits a $30 Primary Copay or a $45 Specialist Copay per visit	$5 per visit for the first 20 visits; after 20 visits a $20 Primary Copay or a $35 Specialist Copay per visit

	CHOICE PLUS		EPO CHOICE	COINSURED CHOICE
■ Outpatient Surgery-Facility	Copay is not applicable, Coinsurance and Deductible apply	Copay is not applicable, Coinsurance and Deductible apply	$100	Copay is not applicable, Coinsurance and Deductible apply
■ Urgent Care Center Services	$40	Copay is not applicable, Coinsurance and Deductible apply	$45	$35
■ Hospital – Inpatient Stay	$100 per day up to 3 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$125 per day up to 3 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$100 per day up to 4 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$100 per day up to 2 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply
■ Skilled Nursing Facility/ Inpatient Rehabilitation Facility Services	$100 per day up to 3 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$125 per day up to 3 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$100 per day up to 4 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$100 per day up to 2 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply

	CHOICE PLUS		EPO CHOICE	COINSURED CHOICE
Annual Deductible[1]				
■ Individual	$400	$1,000	$200	$600
■ Family	Total is not to exceed $400 per person for a total of 2.5 Covered Persons in a family	$1,000 per Individual	Total is not to exceed $200 per person for a total of 2.5 Covered Persons in a family	Total is not to exceed $600 per person for a total of 2.5 Covered Persons in a family
Annual Out-of-Pocket Maximum[1]				
■ Individual	$2,500	$3,500	$1,000	$2,500
■ Family	$5,000	$7,500	Not Applicable	$5,000

	CHOICE PLUS	EPO CHOICE	COINSURED CHOICE
Lifetime Maximum Benefit[2] 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.	Unlimited	Unlimited	Unlimited

[1]Copays do not count toward the Annual Deductible or the Out-of-Pocket Maximum. The Annual Deductible counts toward the Out-of-Pocket Maximum for all Covered Health Services.

[2]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.

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*. You must notify Personal Health Support, as described in Section 4, *Personal Health Support* to receive full Benefits before receiving certain Covered Health Services from a Non-Network provider. In general, if you visit a Network provider, that provider is responsible for notifying Personal Health Support before you receive certain Covered Health Services. See Section 6, *Additional Coverage Details* for further information.

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	**Non-Network**	**Network**	**Network**
Acupuncture Services (Copay is per visit) Up to 3 modalities per visit. Up to 30 visits per calendar year	100% after you pay a $25 Primary Copay or $40 Specialist Copay	70% after you meet the Annual Deductible	100% after you pay a $30 Primary Copay or $45 Specialist Copay	100% after you pay a $20 Primary Copay or $35 Specialist Copay
Ambulance Services ■ Emergency Ambulance	$100 Copay	$100 Copay	$100 Copay	$100 Copay
Colonoscopies and other Scopies	100%	70% after you meet the Annual Deductible	100%	100%
■ Scopic Procedures - Facility	100%	70% after you meet the Annual Deductible	100%	100%
■ Scopic Procedures - Physician's Fees for Scopies	100%	70% after you meet the Annual Deductible	100%	100%

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	**Non-Network**	**Network**	**Network**
■ Scopic Procedures - Outpatient Preventive See also Diagnostic and Therapeutic Procedures – Outpatient	100%	70% after you meet the Annual Deductible	100%	100%
Congenital Heart Disease (CHD) Surgeries	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Dental Services - Accident Only	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Diagnostic Procedures - Outpatient **Note**: Scopies are covered at 100%				
■ Diagnostic and Therapeutic Mammography testing	100%	70% after you meet the Annual Deductible	100%	100%
■ Diagnostic Outpatient – Facility	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100% after you meet the Annual Deductible	80% after you meet the Annual Deductible
■ Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	**Non-Network**	**Network**	**Network**
Disposable Medical Supplies ■ Disposable Medical Supplies	100%	70% after you meet the Annual Deductible	100%	100%
■ Diabetes Self-Management Items Benefits are also available under Section 15, Prescription Drugs.	100%	70% after you meet the Annual Deductible	100%	100%
Durable Medical Equipment (DME)	100%	70% after you meet the Annual Deductible	100%	100%
Emergency Room Health Services - Outpatient	100% after you pay $125 per visit unless you are admitted as an inpatient to a Network Hospital within 24 hours of receiving Emergency treatment for the same condition			
Eye Examinations and Vision Therapy See Section 6, *Additional Coverage Details*, for limits.	100% after you pay a $25 Primary Copay or $40 Specialist Copay	70% after you meet the Annual Deductible	100% after you pay a $30 Primary Copay or $45 Specialist Copay	100% after you pay a $20 Primary Copay or $35 Specialist Copay
Home Health Care	100%	70% after you meet the Annual Deductible	100%	100%

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	**Non-Network**	**Network**	**Network**
Hospice Care	100%	70% after you meet the Annual Deductible	100%	100%
Hospital - Inpatient Stay	$100 per day up to 3 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$125 per day up to 3 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$100 per day up to 4 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$100 per day up to 2 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply
Allergy Injections received in a Physician's Office Allergy serum injections are covered under the Physician's Office Services section when billed in addition to any other service.	No Copay, deductible or coinsurance applies for any allergy serum injection when an office visit charge is not assessed	70% after you meet the Annual Deductible	No Copay, deductible or coinsurance applies for any allergy serum injection when an office visit charge is not assessed	No Copay, deductible or coinsurance applies for any allergy serum injection when an office visit charge is not assessed

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	**Non-Network**	**Network**	**Network**
Injections received in a Physician's Office				
■ Primary Care Provider (Copay is per visit)	100% after you pay a $25 Copay	70% after you meet the Annual Deductible	100% after you pay a $30 Copay	100% after you pay a $20 Copay
■ Specialist Physician (Copay is per visit)	100% after you pay a $40 Copay	70% after you meet the Annual Deductible	100% after you pay a $45 Copay	100% after you pay a $35 Copay
Mental Health Services				
■ Hospital - Inpatient Stay	$100 per day up to 3 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$125 per day up to 3 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$100 per day up to 4 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$100 per day up to 2 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply
■ Physician's Office Services (Copay is per visit)	100% after you pay a $25 Primary Copay or $40 Specialist Copay	70% after you meet the Annual Deductible	100% after you pay a $30 Primary Copay or $45 Specialist Copay	100% after you pay a $20 Primary Copay or $35 Specialist Copay

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	**Non-Network**	**Network**	**Network**
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders				
■ Hospital – Inpatient Stay	$100 per day up to 3 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$125 per day up to 3 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$100 per day up to 4 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$100 per day up to 2 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply
■ Physician's Office Services (Copay is per visit)	100% after you pay a $25 Primary Copay or $40 Specialist Copay	70% after you meet the Annual Deductible	100% after you pay a $30 Primary Copay or $45 Specialist Copay	100% after you pay a $20 Primary Copay or $35 Specialist Copay

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	Non-Network	Network	Network
Neurobiological Disorders - Physical Health Services for Autism Spectrum Disorders See also Rehabilitation Services - Outpatient Therapy				
■ Hospital – Inpatient Stay	$100 per day up to 3 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$125 per day up to 3 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$100 per day up to 4 days per confinement Annual Maximum for Copay$1,000 Coinsurance and Deductible apply	$100 per day up to 2 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply
■ Physician's Office Services (Copay is per visit)	100% after you pay a $25 Primary Copay or $40 Specialist Copay	70% after you meet the Annual Deductible	100% after you pay a $30 Primary Copay or $45 Specialist Copay	100% after you pay a $20 Primary Copay or $35 Specialist Copay

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	**Non-Network**	**Network**	**Network**
Nutritional Counseling				
■ Hospital - Inpatient Stay	$100 per day up to 3 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$125 per day up to 3 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$100 per day up to 4 days per confinement Annual Maximum for Copay$1,000 Coinsurance and Deductible apply	$100 per day up to 2 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply
■ Physician's Office Services (Copay is per visit) Limited to three visits per calendar year.	$40 Specialist Copay applies if services are received in a provider's office	70% after you meet the Annual Deductible	$45 Specialist Copay applies if services are received in a provider's office	$35 Specialist Copay applies if services are received in a provider's office
Pharmaceutical Products - Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	**Non-Network**	**Network**	**Network**
Physician's Office Services - Sickness and Injury				
■ Primary Care Provider (Copay is per visit)	100% after you pay a $25 Copay	70% after you meet the Annual Deductible	100% after you pay a $30 Copay	100% after you pay a $20 Copay
■ Specialist Physician (Copay is per visit)	100% after you pay a $40 Copay	70% after you meet the Annual Deductible	100% after you pay a $45 Copay	100% after you pay a $35 Copay
Pregnancy – Maternity Services				
■ Physician's Office Services (No Copay applies for routine prenatal and postnatal visits after the first visit)	100% after you pay a $25 Copay	70% after you meet the Annual Deductible	100% after you pay a $30 Copay	100% after you pay a $20 Copay
■ Physician's Office Services for Newborn	100% after you pay a $25 Primary Copay or a $40 Specialist Copay	70% after you meet the Annual Deductible	100% after you pay a $30 Primary Copay or a $45 Specialist Copay	100% after you pay a $20 Primary Copay or a $35 Specialist Copay

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	**Non-Network**	**Network**	**Network**
■ Hospital - Inpatient Stay	$100 per day up to 3 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$125 per day up to 3 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$100 per day up to 4 days per confinement Annual Maximum for Copay$1,000 Coinsurance and Deductible apply	$100 per day up to 2 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply
- well newborn	90%	70%	100%	80%
- sick newborn An Annual Deductible will apply for a newborn child whose length of stay in the Hospital is longer than the mother's length of stay for delivery of a newborn.	$100 per day up to 3 days per confinement $1,000 Annual Maximum for Copay) Coinsurance and Deductible apply	$125 per day up to 3 days per confinement $1,000 Annual Maximum for Copay) Coinsurance and Deductible apply	$100 per day up to 4 days per confinement $1,000 Annual Maximum for Copay) Coinsurance and Deductible apply	$100 per day up to 2 days per confinement $1,000 Annual Maximum for Copay) Coinsurance and Deductible apply

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	**Non-Network**	**Network**	**Network**
■ Physician Fees for Surgical and Medical Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay for delivery of a newborn.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Preventive Care Services				
■ Physician Office Services	100%	70% after you meet the Annual Deductible	100%	100%
■ Lab, X-ray or Other Preventive Tests	100%	70% after you meet the Annual Deductible	100%	100%
■ Breast Pumps	100%	70% after you meet the Annual Deductible	100%	100%
Prosthetic Devices	100%	70% after you meet the Annual Deductible	100%	100%

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	**Non-Network**	**Network**	**Network**
Reconstructive Procedures				
■ Primary Care Provider (Copay is per visit)	100% after you pay a $25 Copay	70% after you meet the Annual Deductible	100% after you pay a $30 Copay	100% after you pay a $20 Copay
■ Specialist Physician (Copay is per visit)	100% after you pay a $40 Copay	70% after you meet the Annual Deductible	100% after you pay a $45 Copay	100% after you pay a $35 Copay
■ Hospital - Inpatient Stay	$100 per day up to 3 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$125 per day up to 3 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$100 per day up to 4 days per confinement Annual Maximum for Copay$1,000 Coinsurance and Deductible apply	$100 per day up to 2 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply
■ Physician Fees for Surgical and Medical Services	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	**Non-Network**	**Network**	**Network**
■ Prosthetic Devices	100%	70% after you meet the Annual Deductible	100%	100%
■ Surgery – Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Rehabilitation Services and Outpatient Therapy				
■ Physician Office Services (Copay is per visit)	$5 Copay per visit for the first 20 visits. After the 20th visit, a $25 Primary Copay or a $40 Specialist Copay	70% after you meet the Annual Deductible	$5 Copay per visit for the first 20 visits. After the 20th visit, a $30 Primary Copay or a $45 Specialist Copay	$5 Copay per visit for the first 20 visits. After the 20th visit, a $20 Primary Copay or a $35 Specialist Copay
■ Hospital - Inpatient Stay	$100 per day up to 3 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$125 per day up to 3 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$100 per day up to 4 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$100 per day up to 2 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	Non-Network	Network	Network
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Up to 60 days per calendar year	$100 per day up to 3 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$125 per day up to 3 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$100 per day up to 4 days per confinement Annual Maximum for Copay$1,000 Coinsurance and Deductible apply	$100 per day up to 2 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply
Spinal Treatment (Copay is per visit) Up to 3 modalities per treatment Up to 30 treatments per calendar year	100% after you pay a $25 Primary Copay	70% after you meet the Annual Deductible	100% after you pay a $30 Primary Copay	100% after you pay a $20 Primary Copay
Substance Use Disorder Services ■ Hospital - Inpatient Stay (Copay is per admission)	$100 per day up to 3 days per confinement Annual Maximum for Copay $1,000 Coinsurance	$125 per day up to 3 days per confinement Annual Maximum for Copay $1,000 Coinsurance	$100 per day up to 4 days per confinement Annual Maximum for Copay $1,000 Coinsurance	$100 per day up to 2 days per confinement Annual Maximum for Copay $1,000 Coinsurance

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	**Non-Network**	**Network**	**Network**
	and Deductible apply	and Deductible apply	and Deductible apply	and Deductible apply
■ Physician's Office Services (Copay is per visit)	100% after you pay a $25 Primary Copay or $40 Specialist Copay	70% after you meet the Annual Deductible	100% after you pay a $30 Primary Copay or $45 Specialist Copay	100% after you pay a $20 Primary Copay or $35 Specialist Copay
Surgery – Outpatient See also Physician Fees for Surgical and Medical Services				
■ Outpatient Surgery-Facility	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	$100 per surgery	80% after you meet the Annual Deductible
■ Outpatient Surgery-Physician's Office Service	100% after you pay a $25 Primary Copay or $40 Specialist Copay	70% after you meet the Annual Deductible	100% after you pay a $30 Primary Copay or $45 Specialist Copay	100% after you pay a $20 Primary Copay or $35 Specialist Copay
Therapeutic Treatments – Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	**Non-Network**	**Network**	**Network**
Transplantation Services See Section 6, *Additional Coverage Details*, for notification requirements.	$100 per day up to 3 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$125 per day up to 3 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply	$100 per day up to 4 days per confinement Annual Maximum for Copay$1,000 Coinsurance and Deductible apply	$100 per day up to 2 days per confinement Annual Maximum for Copay $1,000 Coinsurance and Deductible apply
Urgent Care Center Services (Copay is per visit)	100% after you pay a $40 Copay	70% after you meet the Annual Deductible	100% after you pay a $45 Copay	100% after you pay a $35 Copay

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to notify Personal Health Support before you receive them, and any reduction in Benefits that may apply if you do not call Personal Health Support.

This section supplements the second table in Section 5, *Plan Highlights*.

While the second table in Section 5 provides you with some of the benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, and Covered Health Services for which you must call Personal Health Support. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions*.

Acupuncture Services

The Plan pays for acupuncture services provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine;
- Doctor of Osteopathy;
- Chiropractor; or
- Acupuncturist.

Covered Health Services include:

- pain therapy
- treatment of nausea as a result of:
    - chemotherapy;
    - first trimester of Pregnancy; and
    - post-operative procedures.

Each treatment is limited to 3 modalities during a visit. Covered Health Services are limited to a total of 30 treatments per calendar year.

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that is medically equipped to provide the needed Emergency Room Health Services. See Section 14, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Room Health Services.

In most cases, UnitedHealthcare will coordinate and direct non-Emergency ambulance transportation. The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- from a Non-Network Hospital to a Network Hospital;
- to a Hospital that provides a higher level of care that was not available at the original Hospital;
- to a more Cost-Effective acute care facility; or
- from an acute facility to a sub-acute setting.

If you are requesting non-Emergency ambulance services, you must notify Personal Health Support as soon as possible before the transport. If Personal Health Support is not notified, you will be responsible for paying all charges and no Benefits will be paid.

Cancer Resource Services (CRS)

Cancer Resource Services is a program administered by UnitedHealthcare or its affiliates made available to you by Travis County. The CRS program provides:

- specialized consulting services, on a limited basis, to Covered Persons with cancer;
- access to cancer centers with expertise in treating the most rare or complex cancers; and
- education to help patients understand their cancer and make informed decisions about their care and course of treatment.

The Plan pays Benefits for oncology services provided by Designated Facilities participating in the Cancer Resource Services (CRS) program even if the facility is not a Network Facility. Designated Facility is defined in Section 14, *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If a Covered Person has cancer, you may:

- be referred to CRS by a Personal Health Support Nurse;
- call CRS toll-free at (866) 936-6002; or
- visit www.urncrs.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Facility. If you receive oncology services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay;
- Surgery - Outpatient;
- Diagnostic Outpatient – Facility; and
- Therapeutic Services - –CT, Pet Scans, MRI and Nuclear Medicine – Outpatient

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with cancer-related services received at a Designated Facility.

To receive Benefits under the CRS program, you must contact CRS before obtaining Covered Health Services.

Colonoscopies and other Scopies

The Plan pays for diagnostic and therapeutic scopic procedures and related services including laboratory charges received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment;
- laboratory charges, and
- Physician services for anesthesiologists, pathologists and radiologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Please note that Benefits under this section do include scopic procedures, which are for the purpose of performing surgery. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD services:

- outpatient diagnostic testing;
- evaluation;
- surgical interventions;
- interventional cardiac catheterizations (insertion of a tubular device in the heart);
- fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology); and
- approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks or Personal Health Support to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the toll-free number on your ID card for information about CHD services.

If you receive Congenital Heart Disease services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments – Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program.

Dental Services - Accident Only

Dental services are covered by the Plan only when all of the following are true:

- treatment is necessary because of damage resulting from accidental injury or radiation therapy or chemotherapy that occurred while the Covered Person is covered by this Plan;
- dental damage does not occur as a result of normal activities of daily living, such as chewing or eating ice, or extraordinary use of the teeth;
- the Physician or dentist has certified that the pre-damage condition of the injured tooth was that of a sound, natural tooth, or a restored tooth, or a prosthesis in good condition;
- dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and
- in the case of damage from accidental injury, the dental damage is severe enough that initial contact with a Physician or dentist occurs within 96 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the accidental Injury and if extenuating circumstances exist due to the severity of the accidental Injury.)

Only the least costly, dentally necessary treatment to restore the injured tooth to its pre-damage condition will be considered a Covered Benefit in these circumstances. Dental services for final treatment to repair the damage caused by accidental Injury must be started within three months of the accident unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident. Dental services to repair the damage caused by radiation therapy or chemotherapy must be started within three months of the diagnosis of the damage unless extenuating circumstances exist (such as prolonged therapy causing additional damage) and completed within 12 months of the diagnosis of the damage.

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to direct treatment of acute traumatic Injury and damage due to radiation therapy and chemotherapy.

The Plan pays for treatment of damage resulting from accidental Injury or radiation therapy or chemotherapy only for:

- emergency examination;
- necessary diagnostic x-rays;
- endodontic (root canal) treatment;
- temporary splinting of teeth;
- prefabricated post and core;
- simple minimal restorative procedures (fillings);
- extractions;
- post-traumatic crowns if such are the only clinically acceptable treatment; and

- replacement of teeth lost due to the Injury.

You should notify Personal Health Support as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins if you have accidental Injury. You do not have to provide notification before the initial Emergency treatment. When you provide notification, Personal Health Support can determine whether the service is a Covered Health Service.

Diagnostic Procedures Outpatient

Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:

- Lab;
- Radiology/X-ray; and
- Mammography testing.

Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a Physician's office, Benefits are described under Physician's Office Services below.

Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine

Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including CT scans, PET scans, MRI, and nuclear medicine.

Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a Physician's office, Benefits are described under Physician's Office Services below.

Disposable Medical Supplies and Equipment

The Plan covers Disposable Medical Supplies that meet each of the following criteria:

- Ordered or provided by a Physician for outpatient use.
- Used for medical purposes to treat a Sickness, Injury or their symptoms.
- Not generally useful to a person in the absence of a Sickness, Injury or their symptoms.
- Appropriate for use in the home.
- Available through a medical supplier and not generally available in grocery or general merchandise stores.

Examples of Disposable Medical Supplies include the following:

- Two medically appropriate pairs of elastic stockings each year,
- Gauze and dressings when used with Durable Medical Equipment.
- Ostomy Supplies:
  - Pouches, Face Plates and belts

- Irrigation sleeves, bags and catheters
- Skin Barriers
- Deodorants
- Filters
- Lubricants
- Tape
- Appliance Cleaners
- Adhesive and Adhesive Remover

- Diabetic Self-Management Items including the following:
  - Standard insulin syringes with needles,
  - Blood testing strips – glucose,
  - Urine testing strips – glucose,
  - Ketone testing strips and tablets,
  - Lancets and lancet devices,
  - Glucometers (every two years)

- Inhaler spacers.
- Intravenous tubing.
- Respiratory therapy supplies.
- Oxygen and tubing, connectors and masks necessary to administer oxygen or for delivery pumps for tube feedings when used with Durable Medical Equipment.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- ordered or provided by a Physician for outpatient use;
- used to serve a medical purpose with respect to treatment of a Sickness, Injury or disability;
- not consumable or disposable;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use and primarily used in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you may be responsible for any cost difference between the piece you rent or purchase and the piece UnitedHealthcare has determined is the most Cost-Effective.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- standard Hospital beds;
- delivery pumps for tube feedings;
- burn garments;
- insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section;
- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces to treat curvature of the spine. Braces that straighten or change the shape of a body part such as arm, leg and neck. (However orthotic shoes or shoes with inserts are excluded from coverage unless attached to a brace. Dental braces are excluded from coverage.); and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

In conjunction with cochlear implantation, Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. ***Note:*** DME is different from prosthetic devices – see *Prosthetic Devices* in this section.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every three calendar years, if functionally necessary.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than three years. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at anytime and are not subject to the three year timeline for replacement.

If you are enrolled in the Choice Plus Plan, for Non-Network Benefits you must notify Personal Health Support if the purchase, rental, repair or replacement of DME will cost more than $1,000. You must purchase or rent the DME from the vendor Personal Health Support identifies. If Personal Health Support is not notified, Benefits will be subject to a $250 penalty. This notification does not apply if you are enrolled in the Choice or CoInsured Plans.

Emergency Room Health Services - Outpatient

The Plan's Emergency Room Health Services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

Regardless of the Plan in which you are enrolled, if you are admitted as an inpatient to a Network Hospital for the same condition within 24 hours of receiving treatment for an Emergency Room Health Service, you will not have to pay the Copay for Emergency Room Health Services. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.

If you are enrolled in the Choice Plus Plan, Network Benefits will be paid for an Emergency admission to a Non-Network Hospital as long as Personal Health Support is notified within one business day of the admission or on the same day of admission if reasonably possible after you are admitted to a Non-Network Hospital. If you continue your stay in a Non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Non-Network Benefits will apply.

If you are enrolled in the Choice, or CoInsured Plans, Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as Personal Health Support is notified within one business day of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, no Benefits will be paid.

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

If you are enrolled in the Choice Plus Plan, you must notify Personal Health Support within one business day of the admission or on the same day of admission if reasonably possible if you are admitted to a Non-Network Hospital as a result of an Emergency. If Personal Health Support is not notified, Benefits for the Inpatient Hospital Stay will be subject to a $250 penalty. This notification does not apply if you are enrolled in the Choice or CoInsured Plans.

Eye Examinations and Vision Therapy

Eye examinations received from a health care provider in the provider's office. Network Benefits include one routine vision exam, including refraction, to detect vision impairment by a Network Provider each calendar year. Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

Vision therapy (Synonyms include: eye muscle exercise therapy, optometric visual therapy, vision training, orthoptic training and pleoptic training).

Orthoptic training (Vision therapy) is limited to a lifetime maximum of 20 visits for each Employee or adult Dependent. Covered Services are limited to a lifetime maximum of 30 visits for each Dependent child.

Home Health Care

Home Health Care Services are services that require clinical training to be delivered safely and effectively and are provided by a program or organization authorized by law to provide health care services in the home if you need care in your home due to the nature of your condition. Services must be:

- ordered by a Physician;
- provided in your home by a registered nurse, or by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- provided to obtain a specified medical outcome and provide for your safety as a patient;
- provided on a part-time, intermittent schedule.

Personal Health Support will decide if Skilled Care is needed 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.
- assistance is needed with activities of daily living, which include but are not limited to dressing, feeding, bathing, ostomy care, incontinence care, checking of routine vital signs, or transferring from a bed to a chair or ambulating.

If you are enrolled in the Choice Plus Plan, please remember for Non-Network Benefits, you must notify Personal Health Support five business days before receiving services or as soon as reasonably possible. If Personal Health Support is not notified, Benefits will be subject to a $250 penalty. This notification does not apply if you are enrolled in the Choice or CoInsured Plans.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

If you are enrolled in the Choice Plus Plan, please remember for Non-Network Benefits, you must notify Personal Health Support one business days before receiving services. If Personal Health Support is not notified, Benefits will be subject to a $250 penalty. This notification does not apply if you are enrolled in the Choice or CoInsured Plans.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- non-Physician services and supplies received during an Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); or a private room where a semi-private is not available or a private room is appropriate in terms of generally accepted medical practice and
- Physician services for anesthesiologists, Emergency room Physicians, consulting Physicians, pathologists and radiologists.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Room Health Services - Outpatient* and *Surgery - Outpatient, Scopic Procedures - Diagnostic and Therapeutic Services*, and *Therapeutic Treatments - Outpatient*, respectively.

If you are enrolled in the Choice Plus Plan, please remember for Non-Network Benefits, you must notify Personal Health Support as follows:

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

If Personal Health Support is not notified, Benefits will be subject to a $250 penalty. This notification does not apply if you are enrolled in the Choice or CoInsured Plans.

Allergy Injections received in a Physician's Office

The Plan pays for Benefits for allergy serum injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.

When other health services are received, Benefits are described under *Physician's Office Services*.

Allergists are considered as primary care.

When you go to the Physician's office and get an allergy shot from the nurse and do not receive any additional services, you will not be required to pay a copay, coinsurance or deductible.

When additional services are received during your visit to the Physician's office to receive an allergy shot, Benefits will be paid as described under Physician's Office Services.

Injections received in a Physician's Office

The Plan pays for Benefits for injections received in a Physician's office when no other health service is received.

When other health services are received, Benefits are described under *Physician's Office Services*.

Kidney Resource Services (KRS)

Kidney Resource Services (KRS) is a program that provides:

- specialized consulting services to Covered Persons with End Stage Renal Disease (ESRD) or chronic kidney disease;
- access to dialysis centers with expertise in treating kidney disease; and
- guidance for the patient on the prescribed plan of care.

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) disease provided by Designated Facilities participating in the Kidney Resource Services (KRS) program. Designated Facility is defined in Section 14, *Glossary*.

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self refer to a Network provider participating in the program. Notification is required:

- prior to vascular access placement for dialysis; and
- prior to any ESRD services.

A Covered Person may:

- be referred to KRS by Personal Health Support; or
- call KRS toll-free at (888) 936-7246 and select the KRS prompt.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Facility. If you receive services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services.

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, group therapeutic services and provider-based case management services; and
- crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Outpatient Benefits include Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for the inpatient treatment. 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.

Special Mental Health 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 Services benefit. The Mental Health Services Benefits and financial requirements assigned to 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 which may not otherwise be covered under this Plan. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

If you are enrolled in the Choice Plus Plan, please remember for Non-Network Benefits, you must notify the Mental Health/Substance Use Disorder Administrator to receive inpatient Benefits in advance of any treatment. Please call the phone number that appears on your ID card. Without notification, Benefits will be subject to a $250 penalty. This notification does not apply if you are enrolled in the Choice or CoInsured Plans.

Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders

These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorders. The Plan only pays Benefits for psychiatric services for Autism Spectrum Disorders that are both of the following:

- provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and
- focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others or property or that are impairing daily functioning or both.

Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders 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, group therapeutic services and provider-based case management services; and
- crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Outpatient Benefits include 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.

Note: 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.

If you are enrolled in the Choice Plus Plan, for Non-Network Benefits, you must notify the Mental Health/Substance Use Disorder Administrator to receive inpatient Benefits. Please call the phone number that appears on your ID card. Without notification, Benefits will be subject to a $250 penalty. This notification does not apply if you are enrolled in the Choice or CoInsured Plans.

Neurobiological Disorders – Physical Health Services for Autism Spectrum Disorders

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

- diagnostic evaluations and assessment services;
- applied behavior analysis;
- behavior training and behavior management;
- speech therapy;
- occupational therapy;
- physical therapy; or
- medications or nutritional supplements used to address symptoms of autism spectrum disorder.

Note: 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.

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional when:

- education is required for a disease in which patient self-management is an important component of treatment; and
- there exists a knowledge deficit about the disease which requires the intervention of a trained health professional.

Nutritional Counseling is limited to three visits per calendar year.

Some examples of such medical conditions include:

- coronary artery disease;
- congestive heart failure;
- severe obstructive airway disease;
- gout (a form of arthritis);
- renal failure;

- phenylketonuria (a genetic disorder diagnosed at infancy);
- hyperlipidemia (excess of fatty substances in the blood); and
- diabetes.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered by or the administration of which must be directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility, Outpatient Surgical Facility and Physicians office, or for Physician house calls.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services received in a Physician's office for the evaluation and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital. Benefits under this section include allergy injections, allergy testing, and hearing exams in case of Injury or Sickness.

When you go to the Physician's office and get an allergy shot from the nurse and you receive additional services, such as allergy testing, you will be required to pay a copay or coinsurance after satisfying the applicable deductible.

When a Physician performs professional services to mix the allergy serum, the fees for this are not subject to the copay.

Benefits for preventive services are described under *Preventive Care* in this section

Benefits under this section include lab, radiology/x-ray or other diagnostic services performed in the Physician's office.

Please Note
Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Covered Mother

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, delivery, postnatal care, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

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

These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer stays. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Examples of additional Covered Services related to pregnancy are:

- Birthing Center Services including room and board, anesthetics.
- Nurse-Midwife services by a licensed or certified Nurse-Midwife.
- Routine Well Baby care before the mother is released from the hospital including nursery care, circumcision by a surgeon and Physician services when the baby is healthy.

If you are enrolled in the Choice Plus Plan, for Non-Network Benefits, you must notify Personal Health Support as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above. If Personal Health Support is not notified, Benefits for the extended stay will be subject to a $250 penalty. This notification does not apply if you are enrolled in the Choice or CoInsured Plans.

If the mother is sick and is inpatient longer than the federally mandated requirements stated above, but the newborn is discharged from the hospital, any fees for the newborn to continue to stay are not covered by the Plan.

The annual deductible is waived on the newborn's fees during the time when the mother and newborn are in the hospital together. This annual deductible waiver applies to all of the newborn's eligible inpatient claims including, but not limited to, physician fees and facility fees. However, if the newborn stays longer than the mother the newborn's annual deductible will apply upon the mother's discharge from the hospital.

Newborn Benefits when Mother is not Covered under the Plan

If the newborn's birth mother is not covered under the Plan, the baby's annual deductible is not waived. The Plan applies the newborn's coinsurance and deductible under the newborn.

Healthy moms and healthy babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Resources to Help you Stay Healthy*, for details.

Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital include medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes. The services in the following four bullets are required under applicable law. The details about these services are found online at the sites listed:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; You can find the list of preventive services that have a rating of "A" or "B" from the USPSTF by visiting http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration found online at http://www.hrsa.gov/index.html; and
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. Current recommendations and wellness guidelines for specific populations are found online at http://www.ahrq.gov/.

You will find examples of services on those sites.

Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 5, *Plan Highlights,* under *Covered Health Services.*

Benefits are only available if breast pumps are obtained from a DME provider, Hospital or Physician.

Prosthetic Devices

The Plan pays for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- artificial arms, legs, feet and hands;
- artificial eyes, ears and nose; and

- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are provided for the replacement of a type of prosthetic device once every three calendar years.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a necessary mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. 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 UnitedHealthcare at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure may be to improve the appearance of a body part and the procedure is cosmetic. Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without

improving or restoring physiologic function are also considered Cosmetic Procedures. An example of this is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, *Glossary*.

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.

You must notify Personal Health Support five business days before undergoing any Reconstructive Procedure. When you provide notification, Personal Health Support can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage.

Rehabilitation Services - Outpatient Therapy

The Plan provides short-term outpatient rehabilitation services for the following types of therapy:

- physical therapy;
- occupational therapy;
- speech therapy;
- post-cochlear implant aural therapy;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider must perform the services under the direction of a Physician. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

The Plan will pay Benefits for speech therapy only when the speech impediment or dysfunction results from Injury, Sickness, stroke, cancer, Autism Spectrum Disorders or a Congenital Anomaly, or is needed following the placement of a cochlear implant.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

When Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan, Benefits include:

- non-Physician services and supplies received during the Inpatient Stay; and
- room and board in a Semi-private Room (a room with two or more beds); and

- Physician services for anesthesiologists, consulting Physicians, pathologists and radiologists.

Benefits are available when Skilled Care and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

UnitedHealthcare will determine if Benefits are available by reviewing both the skill level of the services required 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 available only if:

- the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost-Effective alternative to an Inpatient Stay in a Hospital; and
- you will receive primarily Skilled Care services that are not primarily Custodial Care as described in Section 8, *Exclusions*.

Skilled Care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

- it is 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; and
- it requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care as described in Section 8, *Exclusions,* or domiciliary care, even if ordered by a Physician.

Benefits are limited to a total of 60 days per calendar year.

If you are enrolled in the Choice Plus Plan, for Non-Network Benefits, you must notify Personal Health Support as follows:

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

- for Emergency admissions: within one business day or the same day of admission, or as soon as is reasonably possible.

If Personal Health Support is not notified, Benefits will be subject to a $250 penalty. This notification does not apply if you are enrolled in the Choice or CoInsured Plans.

Spinal Treatment

A Spinal Treatment is using manual or mechanical means to detect or correct subluxation in the body to remove nerve interface or its effects. The interference must result from or relate to distortion, misalignment or subluxation of or in the vertebral column.

Benefits for Spinal Treatment are only covered when provided by an appropriately licensed provider in the provider's office. Benefits include diagnosis and related services and are limited to three modalities of treatment per day. Benefits for Spinal Treatment are limited to a combined total of 30 visits per calendar year.

Soft tissue modalities are a Covered Health Service when performed in an office setting by a covered provider.

Substance Use Disorder Services

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.

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

- diagnostic evaluations and assessment;
- treatment planning;
- referral services;
- medication management;
- individual, family, group therapeutic services and provider-based case management;
- crisis intervention; and
- detoxification (sub-acute/non-medical).

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Outpatient Benefits include Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for the inpatient treatment. 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.

Special 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 Substance Use Disorder Services benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to 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 substance use disorder which may not otherwise be covered under this Plan. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

If you are enrolled in the Choice Plus Plan, for Non-Network Benefits, you must notify the Mental Health/Substance Use Disorder Administrator to receive inpatient Benefits. Please call the phone number that appears on your ID card. Without notification, Benefits will be subject to a $250 penalty. This notification does not apply if you are enrolled in the Choice or CoInsured Plans.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- education is required for a disease in which patient self-management is an important component of treatment; and

- there exists a knowledge deficit about the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- the facility charge and the charge for related supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists.
- Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

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

Transplantation Services

Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a provider. The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Examples of transplants for which Benefits are available include but are not limited to:

- heart;
- heart/lung;
- lung;
- kidney;
- kidney/pancreas;
- liver;
- liver/kidney;
- liver/intestinal;
- pancreas;
- intestinal;
- bone marrow (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), and
- cornea transplants that are provided by a provider at a Hospital. (You are not required to notify United Resource Networks or Personal Health Support of a cornea transplant).

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Plan has specific guidelines about Benefits for transplant services. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the telephone number on your ID card for information about these guidelines.

If you are enrolled in the Choice Plus Plan, for Non-Network Benefits, you must notify United Resource Networks or Personal Health Support as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If United Resource Networks or Personal Health Support is not notified, Benefits will be subject to a $250 penalty. This notification does not apply if you are enrolled in the Choice or CoInsured Plans.

Travel and Lodging

United Resource Networks or Personal Health Support will assist the patient and family with travel and lodging arrangements related to:

- Congenital Heart Disease (CHD);
- transplantation services; and
- cancer-related treatments.

Provided the patient is not covered by Medicare, the Plan covers expenses for travel and lodging for the patient and a companion as follows:

- transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the cancer-related treatment, the CHD service, or the transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up;
- Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion. Benefits are paid at a per day rate of up to $100 per day for the patient or up to $200 per day for the patient plus one companion; or
- if the patient is an enrolled dependent minor child, the transportation of the patient and up to two companions who are traveling to and/or from the site of the transplant and Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and up to two companions. Benefits are paid at a per day rate of up to $100 per day for the patient or up to $300 per day for the patient plus two companions.

Travel and lodging expenses are only available if the recipient lives more than 50 miles from the facility for CRS and transplantation or the CHD facility. UnitedHealthcare must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

- airfare at coach rate or economy class;
- taxi or ground transportation; or
- mileage reimbursement at the IRS rate for the most direct route between the patient's home and the facility.

Support in the event of serious illness

If a Covered Person has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *Glossary*.

When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section.

SECTION 7 - RESOURCES TO HELP YOU STAY HEALTHY

What this section includes:
Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools;
- Disease and Condition Management Services; and
- Wellness Programs.

Travis County believes in giving you the tools you need to be an educated health care consumer. To that end, Travis County has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and Travis County are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Consumer Solutions and Self-Service Tools

Health Assessment

You and all of your Covered Dependents are invited to learn more about your health and wellness at **www.myuhc.com** and are encouraged to participate in the online health assessment. The health assessment is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health assessment is kept confidential. Completing the assessment will not impact your Benefits or eligibility for Benefits in any way.

To find the health assessment, log in to **www.myuhc.com**. After logging in, access your personalized *Health & Wellness* page and click the *Health Assessment* link. If you need any assistance with the online assessment, please call the number on the back of your ID card.

Health Improvement Plan

You can start a Health Improvement Plan at any time. This plan is created just for you and includes information and interactive tools, plus online health coaching recommendations based on your profile.

Online coaching is available for:

- nutrition;
- exercise;
- weight management;
- stress;
- smoking cessation;
- diabetes; and
- heart health.

To help keep you on track with your Health Improvement Plan and online coaching, you'll also receive personalized messages and reminders – Travis County's way of helping you meet your health and wellness goals.

NurseLine℠

NurseLine is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, and seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that Travis County has available to help you improve your health and well-being or manage a chronic condition. Consider putting the NurseLine number in your cell phone directory so that you can call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take Prescription Drugs safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

Your child is running a fever and it's 1:00 AM. What do you do?

Call NurseLine toll-free, any time, 24 hours a day, and seven days a week. You can count on NurseLine to help answer your health questions.

Note: If you have a medical Emergency, call 911 instead of calling NurseLine.

NurseLine gives you another convenient way to access health information either on the telephone or on-line. By calling the same toll-free number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine is available to you at no cost.

With NurseLine, you also have access to nurses online. To use this service, log onto **www.myuhc.com** and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, and seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Note: If you have a medical Emergency, call 911 instead of logging onto **www.myuhc.com**.

Reminder Programs

To help you stay healthy, UnitedHealthcare may send Covered Persons reminders to schedule recommended screening exams. Examples of reminders include:

- mammograms for women;
- pediatric and adolescent immunizations;
- cervical cancer screenings for women between the ages of 20 and 64;
- comprehensive screenings for individuals with diabetes; and
- influenza/pneumonia immunizations for enrollees age 65 and older.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

Treatment Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Treatment Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer;
- coronary disease.

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care; and

- information on high quality providers and programs.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information about the program, please contact the number on the back of your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for Network providers available in your Plan through the online provider directory;
- access all of the content and wellness topics from NurseLine including Live Nurse Chat 24 hours a day, seven days a week;
- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your UnitedHealthcare ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Copays, Coinsurance, and Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or, print a temporary ID card.
- research health topics of interest to you.
- learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease and Condition Management Services

HealtheNotes℠

UnitedHealthcare provides a service called HealtheNotes to help educate Members and make suggestions about your medical care. HealtheNotes provides you and your Physician with suggestions about preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 14, *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions about your health and the identified suggestions. Any decisions about your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Wellness Programs

Healthy Pregnancy and Parenting Program

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. This program offers:

- Pregnancy consultation to identify special needs;
- written and on-line educational materials and resources;
- 24-hour toll-free access to experienced maternity nurses;
- a phone call from a care coordinator during your Pregnancy, to see how things are going; and
- a phone call from a care coordinator approximately four weeks after delivery to give you additional information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time. To enroll, call the toll-free number on the back of your ID card.

As a program Member, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

SECTION 8 - EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Additional Coverage Details.*

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the SPD says "this includes," or "including but not limiting to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

Alternative Treatments

1. acupressure
2. aromatherapy;
3. hypnotism;
4. massage therapy;
5. Rolfing (holistic tissue massage);
6. Ecological or environmental medicine, diagnosis or treatment.
7. Herbal medicine, holistic or homeopathic care, including drugs. and
8. art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complimentary and Alternative Medicine (NCCAM) of the National Institutes of Health.

This exclusion does not apply to Spinal Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, *Additional Coverage Details.*

Dental

1. dental care, except as identified under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*;

   Endodontics, periodontal surgery and restorative treatment are excluded.

2. diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include:

   - extractions (including wisdom teeth);
   - restoration and replacement of teeth;
   - medical or surgical treatments of dental conditions; and
   - services to improve dental clinical outcomes;

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details*.

3. dental implants , bone grafts, and other implant-related procedures;

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details*.

4. dental braces (orthodontics);

5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia; and the only exceptions to this are for the direct treatment of acute traumatic Injury.

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in Section 6, *Additional Coverage Details*.

6. treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

Devices, Appliances and Prosthetics

1. devices used specifically as safety items or to affect performance in sports-related activities;

2. orthotic appliances and devices that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*:

   Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.

3. the following items are excluded, even if prescribed by a Physician:

   - enuresis alarm;
   - non-wearable external defibrillator;
   - trusses;
   - ultrasonic nebulizers;

4. the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect;

5. the replacement of lost or stolen prosthetic devices;

6. devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details* ; and

7. oral appliances for snoring.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See Section 15, *Prescription Drugs*, for coverage details and exclusions for that separate benefit.

1. Prescription Drugs for outpatient use that are filled by a prescription order or refill;

2. self-injectable medications (This exclusion does not apply to medications which, due to their characteristics, as determined by UnitedHealthcare, must typically be administered or the administration of which must be directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting);

3. growth hormone therapy;

4. non-injectable medications given in a Physician's office except as required in an Emergency and consumed in the Physician's office; and

5. over the counter drugs and treatments.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services or Unproven Services, unless the Plan has agreed to cover them on an exception basis as described in the *Glossary*.

   This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

Foot Care

1. routine foot care including:

   - cutting or removal of corns and calluses;
   - nail trimming or cutting; and
   - debriding (removal of dead skin or underlying tissue);

2. hygienic and preventive maintenance foot care. Examples include:

   - cleaning and soaking the feet;
   - applying skin creams in order to maintain skin tone; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot;

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

3. treatment of flat feet;

4. treatment of subluxation of the foot;

5. shoe inserts;

6. arch supports;

7. shoes (standard or custom), lifts and wedges; and

8. shoe orthotics unless they are attached to a brace.

Medical Supplies and Equipment

1. prescribed or non-prescribed medical supplies. An example of supplies that are not covered includes but is not limited to more than two pairs of medically approved elastic stockings per year.

This exclusion does not apply to:

- ostomy bags and related supplies for which Benefits are provided as described under *Disposable Medical Supplies* in Section 6, *Additional Coverage Details*.
- disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Disposable Medical Supplies* in Section 6, *Additional Coverage Details*; or
- diabetic supplies for which Benefits are provided as described under *Disposable Medical Supplies* in Section 6, *Additional Coverage Details*.

2. tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment;

3. the repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect;

4. the replacement of lost or stolen Durable Medical Equipment; and

5. deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Disposable Medical Supplies* in Section 6, *Additional Coverage Details*.

Mental Health/Substance Use Disorder

Exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders* and/or *Substance Use Disorder Services* in Section 6, *Additional Coverage Details*.

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;
   - 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 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 and paraphilias (sexual behavior that is considered deviant or abnormal);

6. educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning except as identified in *Neurobiological Disorders – Physical Health Services for Autism Spectrum Disorders;*

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*;

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. 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.

Nutrition

1. nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy;

2. nutritional counseling for either individuals or groups, except as defined under *Nutritional Counseling* in Section 6, *Additional Coverage Details*;

3. food of any kind. Foods that are not covered include:

   - enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded;
   - foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
   - oral vitamins and minerals;
   - meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
   - other dietary and electrolyte supplements; and

4. health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. television;

2. telephone;

3. beauty/barber service;

4. guest service;

5. supplies, equipment and similar incidentals for personal comfort. Examples include:

   - air conditioners;
   - air purifiers and filters;
   - batteries and battery chargers;
   - dehumidifiers and humidifiers;
   - ergonomically correct chairs;
   - non-Hospital beds, comfort beds, motorized beds and mattresses;
   - breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement;
   - car seats;
   - chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
   - electric scooters;
   - exercise equipment and treadmills;
   - hot tubs, Jacuzzis, saunas and whirlpools;
   - medical alert systems;
   - music devices;
   - personal computers;
   - pillows;
   - power-operated vehicles;
   - radios;
   - strollers;
   - safety equipment;
   - vehicle modifications such as van lifts;
   - video players; and
   - home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

Physical Appearance

1. Cosmetic Procedures, as defined in Section 14, *Glossary*, are excluded from coverage. Examples include:

   - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
   - pharmacological regimens;
   - nutritional procedures or treatments;
   - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
   - hair removal or replacement by any means;
   - treatments for skin wrinkles or any treatment to improve the appearance of the skin;
   - treatment for spider veins;
   - skin abrasion procedures performed as a treatment for acne;
   - treatments for hair loss;
   - varicose vein treatment of the lower extremities, when it is considered cosmetic; and

- replacement or removal of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;

2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments, and diversion or general motivation;

3. weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity;

4. wigs or toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness regardless of the reason for the hair loss; and

5. treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. biofeedback except when prescribed by a Physician for pain management;

2. medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer);

3. rehabilitation services and Spinal Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including but not limited to routine, long-term or maintenance/preventive treatment;

4. speech therapy to treat stuttering, stammering, or other articulation disorders;

5. speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, a Congenital Anomaly or Autism Spectrum Disorders as identified under *Rehabilitation Services – Outpatient Therapy* in Section 6, *Additional Coverage Details*;

6. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;

7. excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty);

8. psychosurgery (lobotomy);

9. treatment of tobacco dependency;

10. chelation therapy, except to treat heavy metal poisoning;

11. Spinal Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, alignment of the vertebral column, such as asthma or allergies;

12. physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter;

13. sex transformation operations;

14. the following treatments for obesity:

    - non-surgical treatment, even if for morbid obesity; and
    - surgical treatment of obesity even if there is a diagnosis of morbid obesity;

15. medical and surgical treatment of hyperhidrosis (excessive sweating);

16. services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered medical or dental in nature;

17. upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumor or cancer. Orthognathic surgery (procedure to correct underbite or overbite) jaw alignment and treatment for the temporomandibular joint, except as treatment of obstructive sleep apnea; and

18. breast reduction except coverage that is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

Providers Services:

1. performed by a provider who is a family member by birth or marriage, including your Spouse, Domestic Partner, Sponsored Dependent, brother, sister, parent or child as described in eligibility in Section 2, *Introduction*;

2. a provider may perform on himself or herself;

3. performed by a provider with your same legal residence;

4. ordered or delivered by a Christian Science practitioner;

5. performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;

6. provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider;

7. which are self-directed to a free-standing or Hospital-based diagnostic facility; and

8. ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:

   - before ordering the service; or
   - after the service is received.

   This exclusion does not apply to mammography testing.

Reproduction

1. health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment

   This exclusion does not apply to diagnosis of infertility.

2. storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue);

3. expenses for surrogate parenting, donor eggs, donor sperm and host uterus;

4. the reversal of voluntary sterilization;

5. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;

6. services provided by a doula (labor aide); and

7. parenting, pre-natal or birthing classes.

Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB)*;

2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;

3. while on active military duty; and

4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

Transplants

1. health services for organ and tissue transplants, except as identified under *Transplantation Services* in Section 6*, Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;

2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and

3. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan)

Travel

1. health services provided in a foreign country, unless required as Emergency Room Health Services; and

2. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services may be reimbursed at the Plan's discretion.

Types of Care

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care;
2. domiciliary care, living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services;
3. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;
4. Private Duty Nursing;
5. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 6, *Additional Coverage Details*;
6. rest cures;
7. services of personal care attendants;
8. work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. implantable lenses used only to correct a refractive error (such as Intacs corneal implants);

2. purchase cost and associated fitting charges for eyeglasses or contact lenses;

3. hearing aids;

4. eye exercise or vision therapy; and

5. surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. autopsies and other coroner services and transportation services for a corpse;

2. charges for:

   - missed appointments;
   - room or facility reservations;
   - completion of claim forms; or
   - record processing.

3. charges prohibited by federal anti-kickback or self-referral statutes;

4. diagnostic tests that are:

   - delivered in other than a Physician's office or health care facility; and
   - self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;

5. expenses for health services and supplies:

   - that do not meet the definition of a Covered Health Service in Section 14, Glossary;
   - that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;
   - that are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
   - that are received before the date your coverage under this Plan begins,
   - 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 this Benefit Plan; or
   - that exceed Eligible Expenses or any specified limitation in this SPD;
   - for which a Non-Network provider waives the Copay, Annual Deductible or Coinsurance amounts;

6. foreign language and sign language services;

7. long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products;

8. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

   - required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration;
   - conducted for purposes of medical research;
   - related to judicial or administrative proceedings or orders; or

- required to obtain or maintain a license of any type;

9. education, training, and bed and board while in an institution which is mainly a school, training institution, a place of rest or a place for the aged;

10. charges made by a Hospital for non-acute care services that may be covered when provided by other appropriate providers.

SECTION 9 - CLAIMS PROCEDURES

What this section includes:

- How Network and Non-Network claims work; and
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Copay or Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Copay or Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a Non-Network provider, you (or the provider if they prefer) should send the bill with a claim form to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached to the bill and both mailed to UnitedHealthcare at the address on the back of your ID card. This does not apply if you are enrolled in the EPO Choice or CoInsured Choice Plans, unless you receive Emergency Room Health Services.

Prescription Drug Benefit Claims

If you wish to receive reimbursement for a prescription, you may submit a post-service claim as described in this section if:

- you are asked to pay the full cost of the Prescription Drug when you fill it and you believe that the Plan should have paid for it; or
- you pay a Copay and you believe that the amount of the Copay was incorrect.

If a pharmacy (retail or mail order) fails to fill a prescription that you have presented and you believe that it is a Covered Health Service, you may submit a pre-service request for Benefits as described in this section.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the toll-free number on your ID card or contacting the Benefit Manager in the Human Resources Management Department. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
- the patient's name, age and relationship to the Member;
- the group number as shown on your ID card;
- the name, address and tax identification number of the provider of the service(s);
- a diagnosis from the Physician;
- the date of service;
- an itemized bill from the provider that includes:
  - the Current Procedural Terminology (CPT) codes;
  - a description of each service and the charge for each service;
  - the date the Sickness or Injury began; and
  - 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 and address of the other insurance company(s).

Failure to provide all the information listed above may delay any reimbursement that may be due to you.

The above information should be filed with us at the address on your ID card. When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Medco Health Solutions, Inc.
P.O. Box 14711
Lexington, KY 40512

After UnitedHealthcare has processed your claim, you will receive payment for the Benefits that the Plan in which you are enrolled allows. It is your responsibility to pay the Non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

UnitedHealthcare will pay Benefits to you unless:

- the provider notifies UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider; or
- you make a written request for the Non-Network provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your provider, and not to a third party, even if your provider has assigned Benefits to that third party.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered dependent, you will receive a Health Statement in the mail. A Health Statement is a single, integrated statement that summarizes the Explanation of Benefits (EOB) information by providing detailed content on your account balances and claim activity. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for Covered Persons online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 14, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Claims
All claim forms must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by Travis County. This 12-month requirement 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.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include:

- the patient's name and identification number as shown on the ID card;

- the provider's name;
- the date(s) of medical service(s);
- the reason you believe your claim for Benefits should be paid and include facts based only on whether or not Benefits are available under the Plan in which you are enrolled, and the proposed treatment or procedure; and
- any clinical documentation or other written information to support your request for claim payment.

Please note that the decision is based only on whether or not Benefits are available under the Plan in which you are enrolled, and the proposed treatment or procedure. The decision for you to receive services is between you and your Physician.

You or your authorized representative may send a written request for an appeal to:

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

For requests for Urgent Care Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is a:

- request for Urgent Care Benefits;
- pre-service request for Benefits;
- post-service claim; or
- concurrent claim.

There are four types of claims:

- Request for Benefits for Urgent Care - a request for Benefits provided in connection with Urgent Care services for treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed to avoid complications and unnecessary suffering;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.
- Concurrent Care – a request to extend an on-going course of treatment was previously approved for a specific period of time or number of treatments beyond that which was previously approved. (The way this request is processed depends on whether the treatment extension is an Urgent Care request or involves a non-urgent circumstance.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from Travis County through its Benefit Manager at its Human Resources Management Department within 60 days after receipt of the first level appeal determination. Travis County must notify you of the appeal determination within 15 days after receiving the completed appeal for a pre-service denial and 30 days after receiving the completed post-service appeal.

The appeal must be in writing and must include at least the following information and authorizations:

- your name and identification number as shown on the ID card;
- the name of the patient whose care is being appealed;
- the name and address of the medical providers involved;
- The reason you believe your claim for Benefits should be paid and include facts based only on whether or not Benefits are available under the Plan in which you are enrolled, and the proposed treatment or procedure;
- copies of all documents previously submitted for consideration to UnitedHealthcare for its review of its decision not to approve coverage for Health Services;
- an authorization for release of medical information to the Benefit Manager, the Appeals Committee panel hearing the appeal, and the County Attorney advising the panel; and
- an authorization for review and discussion of medical information to the Benefit Manager, the Appeals Committee panel hearing the appeal, and the County Attorney advising the panel as necessary to hear and determine the appeal.

The appeal should be enclosed in a sealed envelope or a sealed box and marked "Confidential Appeal" to notify Travis County that the contents should be kept confidential. If the appeal is marked "Confidential Appeal", it will only be opened by the Benefit Manager or the Director of the Human Resources Management Department.

Within five businesses days after receipt of an appeal, the Benefit Manager will establish an Appeal Committee panel of three members from the Appeals Committee appointed by the Commissioners Court. This panel will include at least one licensed medical practitioner with expertise that is appropriate to the medical issue being appealed and the Benefit Manager or

his representative. The Benefit Manager will set the time, location, and agenda for the Appeals Committee hearing and post Open Meetings notices.

The panel will review the information you submitted and hold a hearing to make a decision about the appeal. A representative of the County Attorney may also attend the appeal hearing but cannot vote on the appeal.

The Appeals Committee panel must issue a written decision with reasons for its decision within 7 business days after the Benefit Manager receives the complete written appeal. Written decisions of a panel of the Appeal Committee will not include any information that identifies who you are, like your name or social security number. This 7 business days does not begin until you have provided all of the required information.

Meetings of an Appeals Committee panel must comply with the Texas Open Meetings Act. Notice of meetings must be posted and the panel may go into closed session to discuss the appeal.

You may present information to the Appeals Committee panel at the hearing in both open and closed session. If you present the information in writing, you can preserve the confidentiality of your identity. If you choose to present information orally in person in open session at the hearing of the panel, the fact that you presented the information in this manner acts as a release of the medical information presented to everyone at the open session of the hearing and a waiver of any right you would otherwise have to confidentiality of your identity.

You will be allowed to be present in the closed session unless the panel needs to receive legal advice about the appeal. You will not be allowed to be present for any legal advice that is provided in closed session.

All written information you provide in the appeal, all oral information you provide in closed session at the hearings, and all discussions about any appeal by the Appeal Committee panel must be kept confidential.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. Travis County will review all claims in accordance with the rules established by the U.S. Department of Labor.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Request for Urgent Care Benefits	
You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare at the toll-free number on your ID card as soon as possible to appeal a Request for Urgent Care Benefits.	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours** of receipt of your request
You must then provide a completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of the additional information required
UnitedHealthcare must notify you of the benefit determination within:	**72 hours** after receiving the additional information
If UnitedHealthcare denies your request for Benefits, you must appeal a claims denial no later than:	**180 days** after receiving the initial claim denial
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide the complete request for Benefits information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
■ If the initial request for Benefits is complete, within:	**15 days** after receiving the complete request for Benefits

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
■ If the initial request for Benefits is incomplete, within:	**15 days** after receiving the additional information to complete the request for Benefits
You must appeal an adverse Benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving an adverse benefit determination on the first level appeal
Travis County must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal**

**Travis County may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond its control.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days** after receipt of your claim
You must then provide completed claim information to UnitedHealthcare within:	**45 days** after notice of the incomplete information
UnitedHealthcare must notify you of the benefit determination:	
■ If the initial claim is complete, within:	**30 days** after receipt of the complete claim
■ If the initial claim is incomplete, within:	**30 days** after receiving the completed claim
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination

Post-Service Claims	
Type of Claim or Appeal	**Timing**
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
If you wish to appeal, you must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving an adverse decision on the first level appeal
Travis County must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal**

[2]**Travis County may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond its control.

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 a request for Urgent Care Benefits as defined above, UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours after receipt of your request.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by Travis County, or if Travis County fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of Travis County's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in

the determination letter. A request must be made within four months after the date you received Travis County's decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and insurance ID number;
- your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- a preliminary review by UnitedHealthcare of the request;
- a referral of the request by UnitedHealthcare to the IRO; and
- a decision by the IRO.

Within the applicable timeframe after receipt of the request, [UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the

external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making Travis County's determination. The documents include:

- all relevant medical records;
- all other documents relied upon by Travis County; and
- all other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by Travis County. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing Travis County determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- a final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by Travis County. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

SECTION 10 - COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans;
- How coverage is affected if you become eligible for Medicare; and
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any of the following:

- another employer sponsored health benefits plan;
- a medical component of a group long-term care plan, such as skilled nursing care;
- no-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The primary plan pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

Note: The Coordination of Benefits provision described here does not apply to covered Prescription Drugs as described in Section 15, *Prescription Drugs*. Benefits for Prescription Drugs will not be coordinated with those of any other health coverage plan.

Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;
- your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that

pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:

- the parents are married or living together whether or not they have ever been married and not legally separated; or
- a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;

- if two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - the parent with custody of the child; then
  - the Spouse of the parent with custody of the child; then
  - the parent not having custody of the child; then
  - the Spouse of the parent not having custody of the child;

- plans for active employees pay before plans covering laid-off or employees who retire while covered under the Plan;
- the plan that has covered the individual claimant the longest will pay first. The expenses must be covered in part under at least one of the plans; and
- finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan – Examples

1) Let's say you and your Spouse or Domestic Partner both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as a Member under this Plan, and as a dependent under your Spouse's or Domestic Partner's plan, this Plan will pay Benefits for the Physician's office visit first.

2) Again, let's say you and your Spouse or Domestic Partner both have family medical coverage through your respective employers. You take your dependent child to see a Physician. This Plan will look at your birthday and your Spouse's or Domestic Partner birthday to determine which plan pays first. If you were born on June 11 and your Spouse or Domestic Partner was born on May 30, your Spouse's or Domestic Partner's plan will pay first.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Plan determines the amount it would have paid had it been the only plan involved.
- the Plan pays the entire difference between the allowable expense and the amount paid by the primary plan – as long as this amount is not more than the Plan would have paid had it been the only plan involved.

The maximum combined payment you may receive from all plans cannot exceed 100% of the total allowable expense. For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

Determining the Allowable Expense When This Plan is Secondary

When this Plan is secondary, the allowable expense is the primary plan's Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you do not elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- employees with active current employment status at Travis County age 65 or older and their Spouses age 65 or older; and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

Medicare Cross-Over Program

The Plan offers a Medicare Cross-over Program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. If you enroll for this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses.

Once the Medicare Part A and Part B and DME carrier[s] have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to UnitedHealthcare to process the balance of your claim under the provisions of this Plan.

To participate in the Medicare Cross-over Program, you must complete a separate form authorizing this service and submit it to UnitedHealthcare. Your Spouse can also enroll for this program, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

You can verify that the automated cross-over is in place by determining whether your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier. Until this message appears, you must continue to file secondary claims with UnitedHealthcare.

This cross-over process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

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 Plan and other plans. Travis County's Benefits Manager may get the facts needed from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

Travis County's Benefits Manager does not need to tell or get the consent of any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that UnitedHealthcare should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the County may recover the amount in the form of salary, wages, or benefits payable under any County-sponsored benefit plans, including this Plan. Travis

County also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount by legal action, if necessary.

Refund of Overpayments

If Travis County pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid must make a refund to Travis County if:

- all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- all or some of the payment Travis County made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

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

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

SECTION 11 - SUBROGATION AND REIMBURSEMENT

What this section includes:
- How your Benefits are impacted if you suffer a Sickness or Injury caused by a third party.

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

Right of Recovery

The Plan has the right to recover benefits it has paid on any Covered Person's behalf that were:

- made in error;
- made due to a mistake in fact;
- advanced before you have met the calendar year Deductible; or
- advanced before you have met the Out-of-Pocket Maximum for the calendar year.

Benefits paid because any Covered Person's misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your dependent before you have met the Deductible and/or the Out-of-Pocket Maximum for the calendar year, the Plan will send you a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- submitting a reminder letter to you that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you to discuss any outstanding balance owed to the Plan.

Right to Subrogation

The right to subrogation means the Plan has the right to pursue 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.

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;
- Travis County in workers' compensation cases; or
- 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; or
  - 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. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds you recover from a 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. Any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not 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. A "collateral source" rule shall not 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;
  - 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.
- 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.
- In case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs.

- 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 about the interpretation of the language stated herein.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end; and
- How to continue coverage after it ends.

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, Travis County will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Your coverage under the Plan will end on the earliest of:

- the last day of the month in which your employment with Travis County ends;
- the last day of the month in which you retire under the Plan, unless you continue your coverage as a retired person.
- the date the Plan ends;
- the last day of the month in which you stop making the required contributions unless otherwise required by law;
- the last day of the month in which you are no longer eligible.
- the last day of the month in which UnitedHealthcare receives written notice from Travis County to end your coverage, or the date requested in the notice, if later.

Coverage for your eligible dependents will end on the earliest of:

- the last day of the month in which your coverage ends;
- the last day of the month in which you stop making the required contributions;
- the last day of the month in which UnitedHealthcare receives written notice from Travis County to end your coverage, or the date requested in the notice, if later; or
- the last day of the month in which your dependents no longer qualify as eligible dependents under this Plan.

Other Events Ending Your Coverage

The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if:

- you commit an act, practice, or omission that constitutes 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; or

- you commit an act of physical or verbal abuse that imposes a threat to Travis County's staff, UnitedHealthcare's staff, a provider or another Covered Person.

Note: Travis County has the right to demand that you pay back Benefits Travis County paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Child

If an unmarried enrolled Child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will cover the Child, as long as:

- the Child is incapacitated and dependent, that is, unable to be self-supporting due to a mental or physical condition or disability;
- the Child depends mainly on you for support;
- initially you provide Travis County proof of the Child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age; and
- periodically after that you provide proof, upon Travis County's request, that the Child continues to meet these conditions.

The proof might include medical examinations at Travis County's expense. However, you will not be asked for this information more than once a year. If you do not supply this proof within 31 days, the Plan will no longer pay Benefits for that Child.

As long as the enrolled child is incapacitated and dependent upon you, coverage will continue unless coverage is otherwise terminated in accordance with the terms of the Plan.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined under *COBRA* in Section 14, *Glossary*.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Travis County's Benefits Manager to determine if Travis County is subject to the provisions of COBRA.

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 Travis County's Benefit Administrator if you have questions about your right to continue coverage.

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 were covered under the Plan on the day before a qualifying event:

- a Member;
- a Member's child, including with respect to the Member's children, a child born to or placed for adoption with the Member during a period of continuation coverage under federal law; or
- a Member's Spouse or former Spouse.

Note: A Domestic Partner, a Domestic Partner's child and a Sponsored Dependent are not Qualified Beneficiaries under COBRA.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for Qualified Beneficiaries, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Member's Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your Qualifying Beneficiaries become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Member's child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
Travis County files for bankruptcy under Title 11, United States Code.[2]	36 months	36 months[3]	36 months[3]

Footnotes appear on the following page.

Footnotes:

[1]Subject to the following conditions:
(i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, 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 over the original 18 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.

[2]This is a qualifying event for any retired Member and his or her enrolled Spouse or child if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

[3]From the date of the Member's death if the Member dies during the continuation coverage.

How Your Medicare Eligibility Affects COBRA Coverage for Your Qualified Beneficiaries

The table below outlines how your dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Coverage for Your Qualified Beneficiaries Up To:
You become entitled to Medicare and do not experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of eligibility for coverage for your Spouse and Member's Child under the Plan	36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Member and Travis County costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will only inform a provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began in response to a request from that provider.

While you are a Member in the medical Plan under COBRA, you have the right to change your coverage election:

- during Open Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2*, Introduction*.

Notification Requirements

If your covered Spouse or Member's child(ren) lose coverage due to divorce, legal separation, or loss of dependent status, you or your Spouse or Member's child(ren) must notify the Human Resources Management Department within 60 days of the latest of:

- the date of the divorce, legal separation or loss of eligibility of an enrolled Spouse or Member's child(ren)'s as an enrolled dependent;
- the date your enrolled Spouse or Member's child(ren) would lose coverage under the Plan; or
- the date on which you or your enrolled Spouse or Member's child(ren) are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Spouse or Member's child(ren) must also notify the Travis County's Benefit Manager when a qualifying event occurs that will extend continuation coverage.

If you or your Spouse or Member's child(ren) fail to notify the Travis County's Benefit Administrator of these events within the 60 day period, the Travis County's Benefit Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Travis County's Benefit Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Travis County's Benefit Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide the Human Resources Management Department with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Travis County's Benefit Administrator at the address stated in Section 16, *Important Administrative Information*. The contents of the notice must be such that the Travis County's Benefit Manager is able to determine the covered Employee and Qualified Beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Members who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Members are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Member qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Travis County's Benefit Administrator for additional information. The Member must contact the Travis County's Benefit Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Member will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

When COBRA Ends

COBRA coverage will end before the maximum continuation period shown above if:

- you or your covered Spouse or Member's child(ren) becomes covered under another group medical plan, as long as the other plan does not limit your coverage due to a preexisting condition; or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends;
- you or your covered Spouse or Member's child(ren) becomes entitled to, and enrolls in, Medicare after electing COBRA;
- the first required premium is not paid within 45 days after the date of the COBRA election;

- any other monthly premium is not paid within 30 days of its due date;
- the entire Plan ends; or
- coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: 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 in this section, whichever is earlier.

Uniformed Services Employment and Reemployment Rights Act

A Member who is absent from employment for more than 30 days due to service in the Uniformed Services may elect to continue Plan coverage for the Member and the Member's dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Members may elect to continue coverage under the Plan by notifying the Travis County's Benefit Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount Travis County normally pays on a Member's behalf. If a Member's Military Service is for a period of time less than 31 days, the Member may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

A Member may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Member's absence from work; or
- the day after the date on which the Member fails to apply for, or return to, a position of employment.

Regardless of whether a Member continues health coverage, if the Member returns to a position of employment, the Member's health coverage and that of the Member's eligible dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Member or the Member's eligible dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call Travis County if you have questions about your rights to continue health coverage under USERRA.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for dependent children;
- Your relationship with UnitedHealthcare and Travis County;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan; and
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Travis County's Benefit Administrator will review the order to determine if it meets the requirements for a QMCSO. If the Travis County's Benefit Administrator determines that the order does meet the requirements for a QMCSO, your child will be enrolled in the Plan as your dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Travis County's Benefit Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and Travis County

To make choices about your health care coverage and treatment, Travis County believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit Plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- Travis County and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions;

- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD); and
- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

Travis County and UnitedHealthcare may use individually identifiable information about you to identify procedures, products or services that you may find valuable.

Travis County and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. Travis County and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between Travis County, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not Travis County's agents or employees, and they are not agents or employees of UnitedHealthcare. Travis County and any of its employees are not agents or employees of Network providers, and UnitedHealthcare and any of its employees are not agents or employees of Network providers. Travis County and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. Travis County and UnitedHealthcare are not liable for any act or omission of any provider.

Travis County and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, Travis County and UnitedHealthcare arrange for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

UnitedHealthcare is not considered to be an employer of Travis County or its employees for any purpose with respect to the administration or provision of benefits under this Plan.

Travis County is solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- the payment of Benefits; and
- 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. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own provider;
- are responsible for paying, directly to your provider, any amount identified as a Member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your provider, the cost of any service that is not a Covered Health Service;
- 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); and
- must decide with your provider what care you should receive.

Interpretation of Benefits

Travis County and UnitedHealthcare have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

Travis County and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

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

Information and Records

Travis County and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. Travis County and UnitedHealthcare may request additional information from you to decide your claim for Benefits. Travis County and UnitedHealthcare will keep this information confidential. Travis County and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish Travis County and UnitedHealthcare with all information or copies of records relating to the services provided to you. Travis County and UnitedHealthcare 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 Member's enrollment form. Travis County and UnitedHealthcare agree that such information and records will be considered confidential.

Travis County and UnitedHealthcare 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 Travis County is required to do by law or regulation. During and after the termination of the Plan, Travis County and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

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

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

In some cases, Travis County and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as Travis County.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare 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; or
- a practice called capitation which occurs when a group of Network providers receives a monthly payment from UnitedHealthcare 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.

If you have any questions about financial incentives you may contact the telephone number on your ID card. You can ask 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. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but Travis County recommends that you discuss

participating in these programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

Travis County and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. Travis County and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copays or Coinsurance.

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.

Future of the Plan

Although Travis County currently has no plans to discontinue the Plan, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

Travis County's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or any other reason. A Plan change may transfer Plan assets and debts to another plan or split a Plan into two or more parts. If Travis County does change or terminate a Plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred before the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Travis County decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Travis County and others as may be required by any applicable law.

Plan Document

This Summary Plan Description (SPD) is an overview of your Benefits. If there is a discrepancy between the SPD and the official plan document, the plan document governs. A copy of the plan document is available for your inspection during regular business hours in the office of Travis County's Benefit Manager. You (or your personal representative) may obtain a copy of this document by written request to Travis County's Benefit Manager, for a nominal charge.

SECTION 14 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD.

Addendum – any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments to it apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum is controlling.

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

- surgical services;
- Emergency Room Health Services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance Use Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment Facility).

Amendment – any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by Travis County or UnitedHealthcare. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

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

Benefits – Plan payments for Covered Health Services as described in this SPD, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

CHD – see Congenital Heart Disease (CHD).

COBRA – the acronym for Consolidated Omnibus Budget Reconciliation Act of 1985 which is a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

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

Congenital Heart Disease (CHD) – any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- be passed from a parent to a child (inherited);
- develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; or
- have no known cause.

Cosmetic Procedure – a procedure or service that changes or improves appearance without significantly improving physiological functioning, as determined by UnitedHealthcare. Reshaping a nose with a prominent bump is an example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in any function like breathing or smelling.

Cost-Effective – the least expensive method of treatment or equipment that performs the necessary function.

Covered Health Services – those health related services, supplies or Pharmaceutical Products, which Travis County determines to be:

- provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, Substance Use Disorders, or their symptoms;
- consistent with nationally recognized Scientific Evidence as available, and Prevailing Medical Standards and Clinical Guidelines;
- not generally considered to be provided for the convenience of the Covered Person, Physician, facility or any other person;
- described in Sections 5 and 6, Plan Highlights and Additional Coverage Details;
- provided to a Covered Person and
- not identified in Section 8, *Exclusions*.

In applying this definition, "Scientific Evidence" and "Prevailing Medical Standards and Clinical Guidelines" have the following meanings:

- "Scientific Evidence" means the results of controlled Clinical Trials (scientific studies designed to identify new health services that improve health outcomes in which two or more treatments are compared and the patient is not allowed to choose which treatment is received) or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community; and
- "Prevailing Medical Standards and Clinical Guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

UnitedHealthcare maintains clinical protocols that describe the Scientific Evidence, Prevailing Medical Standards and Clinical Guidelines supporting its determinations about

specific services. You can access these clinical protocols (as revised from time to time) on **www.myuhc.com** or by calling the number on the back of your ID card. This information is available to Physicians and other health care professionals on UnitedHealthcareOnline.

Covered Person – either the Member or an enrolled dependent only while enrolled and eligible for Benefits under the Plan as described under *Eligibility* in Section 2, *Introduction*. References to "you" and "your" throughout this SPD are references to a Covered Person.

Custodial Care – services that do not require special skills or training and that:

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Designated Facility – a facility that has entered into an agreement with UnitedHealthcare or with an organization contracting on behalf of the Plan, to provide Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area.

To be considered a Designated Facility, a facility must meet certain standards of excellence and have a proven track record of treating specific conditions as determined in accordance with UnitedHealthcare's policy guidelines for the medical condition involved.

Domestic Partner – an individual who:

- shares the same permanent residence and the common necessities of life with the Member; and
- has provided Travis County with a completed Certification of Domestic Partnership that includes the names and any required information for any unmarried eligible children of the Domestic Partner for whom coverage is sought.

A Domestic Partner or a Domestic Partner's child is not eligible for COBRA or dependent life coverage. An employee may only cover one other adult as a dependent.

Durable Medical Equipment (DME) – medical equipment that is all of the following:

- ordered or provided by a Physician for outpatient use;
- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not consumable or disposable;

- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

Eligible Expenses for Choice Plus Plan – charges for Covered Health Services that are provided while the Plan is in effect, determined as follows:

For:	Eligible Expenses are Based On:
Network Benefits	■ contracted rates with the provider or ■ when Covered Health Services are received from a Non-Network provider in circumstances that qualify the services to be treated as Network Benefits, the amounts billed by the provider, unless UnitedHealthcare negotiates lower rates.
Non-Network Benefits	■ negotiated rates agreed to by the Non-Network provider and either UnitedHealthcare or one of its vendors, affiliates or subcontractors, at the discretion of UnitedHealthcare; or ■ one of the following: - for Covered Health Services other than Pharmaceutical Products, selected data resources which, in the judgment of UnitedHealthcare, represent competitive fees in that geographic area (i.e maximum allowable charge); - for Covered Health Services that are Pharmaceutical Products, 100% of the amount that the *Centers for Medicare and Medicaid Services (CMS)* would have paid under the Medicare program for the drug determined by either: ♦ reference to available *CMS* schedules; or ♦ methods similar to those used by *CMS*; or ■ 80% of the billed charge; or ■ A fee schedule that UnitedHealthcare develops in accordance with UnitedHealthcare's reimbursement policy guidelines.

Eligible Expenses for Choice and CoInsured Plans – charges for Covered Health Services that are provided while the Plan is in effect, determined as follows:

For:	Eligible Expenses are Based On:
Network Providers	contracted rates with that provider
Non-Network Providers	If you receive Covered Health Services from a non-Network provider in an Emergency, Eligible Expenses are the amounts billed by the provider, unless the Claims Administrator negotiates lower rates.

For certain Covered Health Services, you are required to pay a percentage of Eligible Expenses in the form of a Copay and/or Coinsurance.

Emergency – a serious medical condition or symptom resulting from Injury, Sickness, Mental Illness, or Substance Use Disorders which:

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

Emergency Room Health Services – Covered Health Services necessary for the treatment of an Emergency.

Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time UnitedHealthcare and Travis County make a determination about 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 (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational); or
- the subject of an ongoing Clinical Trial (a scientific study designed to identify new health services that improve health outcomes in which two or more treatments are compared and the patient is not allowed to choose which treatment is received) 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.

Exceptions

If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), and other Covered Health Services have been considered and would not be effective in treating it, UnitedHealthcare and Travis County may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition for that Covered Person only. Prior to such consideration, UnitedHealthcare and Travis County must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) – a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Annual Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and,
- if not covered, the reason(s) why the service or supply was not covered by the Plan.

Hospital – an institution, operated as required by law, which is all of the following:

- primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance use disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and
- has 24 hour nursing services;
- is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations;
- is approved by Medicare as a Hospital;
- is operated continuously with organized facilities for operative surgery on the premises;
- not primarily a place for rest, Custodial Care or care of the aged; and
- not a Skilled Nursing Facility, convalescent home or similar institution.

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

Inpatient Rehabilitation Facility –a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility that provides 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.

Medicaid – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medicare – Parts A, B, C or D, as applicable, 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.

Member – To be eligible for coverage under the Plan, a Member must reside within the United States.

For:	A Member is an enrolled person who:
Plans for Employees	is a regular employee of Travis County who is scheduled to work at least 20 hours per week.
Plans for Retirees	a retiree who retires while covered under the Plan and elects to continue coverage

Member's Child - a natural child or stepchild or legally adopted child of the Member or the Member's Spouse. The term Member's Child also includes a child for whom legal guardianship has been awarded to the Member or the Member's Spouse.

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 Administrator – the organization or individual designated by Travis County who provides or arranges Mental Health and Substance Use Disorder Services under the Plan.

Mental Illness – mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are specifically listed in Section 8, *Exclusions*.

Network – when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with UnitedHealthcare or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. UnitedHealthcare's affiliates are those entities affiliated with UnitedHealthcare through common ownership or control with UnitedHealthcare or with UnitedHealthcare's ultimate corporate parent, including direct and indirect subsidiaries.

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

Network Benefits - Benefits that are paid for Covered Health Services provided by Network provider. Refer to Section 5, *Plan Highlights* for details about how Network Benefits apply.

Non-Network Benefits - Benefits that are paid for Covered Health Services provided by Non-Network providers unless special circumstances apply. Refer to Section 5, *Plan Highlights* for details about how Non-Network Benefits apply. This definition does not apply to Choice or CoInsured Plans.

Open Enrollment – the period of time, determined by Travis County, during which eligible Members may enroll themselves and their eligible dependents under the Plan.

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.

Personal Health Support – programs provided by UnitedHealthcare that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered dependents. Refer to Section 4, *Personal Health Support* for details about this program.

Personal Health Support Nurse – the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition who calls you to assess your progress and provide you with information and education related to your condition and its treatment. Refer to Section 4, *Personal Health Support* for details about this program.

Pharmaceutical Products – FDA-approved prescription pharmaceutical products administered on an outpatient basis in connection with a Covered Health Service which, due to their characteristics (as determined by UnitedHealthcare), must be administered by or the administration of which must be directly supervised by a Physician or other licensed or certified health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

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 a provider is described as a Physician does not mean that Benefits for all services from that provider are available to you under the Plan.

Plan(s) – The Travis County Employee Health Benefit Fund Plan. The Plan options are Choice Plus, Choice or CoInsured. When the SPD says "Plan" without reference to any option it means the information applies to all options. When the SPD references one or more options (i.e. Choice Plus Plan, Choice or CoInsured Plans) it means the information applies on to the referenced option(s).

Plan Sponsor – Travis County.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with carrying a developing offspring in your body.

Primary Care Provider –For Covered Health Services, a Physician who has a majority of his or her practice in general pediatrics, allergy and immunology, internal medicine, obstetrics/gynecology, family practice or general medicine. For Mental Health Services and Substance Use Disorder Services, a person who is providing services in licensed professional counseling (Masters or Ph.D. level), licensed clinical social work (Masters or Ph.D. level), or psychology (Masters or Ph.D. level) is considered on the same basis as a Primary Care Provider for the provision of all services. Any Doctor of Chiropractics, "DC", who is properly licensed and qualified by law to practice chiropractic medicine.

Private Duty Nursing – nursing care that is provided by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.) to a Covered Person on a one-to-one basis by licensed nurses in a home setting when the Skilled Care can be provided by a program or organization authorized by law to provide health care services in the home on a per visit basis for a specific purpose.

Reconstructive Procedure – a procedure performed to address a physical impairment where the expected outcome is restored or improved physiologic function for an organ or body part either to treat a medical condition or to improve or restore that physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

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;
- it provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Administrator;
- 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.

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

Shared Savings Program - the Shared Savings Program provides access to discounts from Non-Network Physicians who participate in that program. UnitedHealthcare will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. While UnitedHealthcare might negotiate lower Eligible Expenses for Non-Network Benefits, the Coinsurance will stay the same as described in Section 5, *Plan Highlights*.

UnitedHealthcare does not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, in benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by Non-Network providers are payable at Network Benefit levels, as in the case of Emergency Room Health Services). When UnitedHealthcare uses the Shared Savings Program to pay a claim, the patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.

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.

Skilled Care – skilled nursing, teaching, and rehabilitation services when:

- they are 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;
- a Physician orders them;
- they require clinical training in order to be delivered safely and effectively; and

- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility – a nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

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 physician who has a majority of his practice in psychiatry is considered a Specialist Physician.

Spinal Treatment – the therapeutic application of chiropractic and/or manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Spouse – an individual to whom you are married in a formal ceremony or at common law.

Sponsored Dependent - A person who:

- currently shares a permanent residence, including shared expenses and responsibilities for the common necessaries of life, and has been living with the Member for at least six consecutive months;
- is over 18 years of age;
- is not married to anyone;
- is not in the active service in the armed forces,
- is related to the Member within three degrees of blood (for example, parent, child, grandparent, grandchild, great grandparent, great grandchild, sibling, niece, nephew, aunt, uncle); and
- has provided the Plan Sponsor with a Certification of Sponsored dependent by the Member confirming that the above qualities truly apply to the relationship between the Member and the person and stating the names and other required information for the person's children for whom coverage is sought.

A Sponsored Dependent is not eligible for COBRA. An employee may only cover one other adult as a dependent.

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.

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:

- 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; or
- 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 – health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies are studies in which 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.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com**.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare and Travis County may, at their discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Before such a consideration, UnitedHealthcare and Travis County must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.
- UnitedHealthcare and Travis County may, in their discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:

- If the service is one that requires review by the U.S. Food and Drug Administration (FDA), it must be FDA-approved.
- It must be performed by a Physician and in a facility with demonstrated experience and expertise.
- The Covered Person must consent to the procedure acknowledging that UnitedHealthcare and Travis County do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
- At least two studies must be available in published peer-reviewed medical literature that would allow UnitedHealthcare and Travis County to conclude that the service is promising but unproven.
- The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare and Travis County's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care – treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Urgent Care Center – a facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- do not require an appointment;
- are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends; and
- provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

SECTION 15 - PRESCRIPTION DRUGS

What this section includes:

- Benefits available for Prescription Drugs;
- How to utilize the retail and mail order service for obtaining Prescription Drugs;
- Any benefit limitations and exclusions that exist for Prescription Drugs; and
- Definitions of terms used throughout this section related to the Prescription Drug Plan.

Prescription Drug Coverage Highlights

The table below provides an overview of the Plan's Prescription Drug coverage. It includes Copay amounts that apply when you have a prescription filled at a Pharmacy. For detailed descriptions of your Benefits, refer to *Retail* and *Mail Order* in this section.

The Benefits described within this section apply to all Plans in the SPD.

You are responsible for paying any amounts due to the pharmacy at the time you receive your prescription drugs.

Covered Health Services[1, 4]	**Percentage of Prescription Drug Cost Payable by the Plan:**	**Percentage of Predominant Reimbursement Rate Payable by the Plan:**
	Network	**Non-Network**
Retail - up to a 31-day supply[2]	100% after you pay a:	
■ tier-1	$10 Copay	
■ tier-2	$30 Copay, plus any applicable Ancillary Charge	
■ tier-3	$50 Copay, plus any applicable Ancillary Charge	
Mail order - up to a 90-day supply[2,3]	100% after you pay a:	
■ tier-1	$20 Copay	
■ tier-2	$60 Copay, plus any applicable Ancillary Charge	
■ tier-3	$100 Copay, plus any applicable Ancillary Charge	

[1]You must notify UnitedHealthcare to receive full Benefits for certain Prescription Drugs. Otherwise, you may pay more out-of-pocket. See *Notification Requirements* in this section for details.

[2]The Plan pays Benefits for Specialty Prescription Drugs as described in this table.

[3]These supply limits do not apply to Specialty Prescription Drugs. Specialty Prescription Drugs from a mail order Network Pharmacy are subject to a 30-day supply limit.

[4]You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Note: The Coordination of Benefits provision described in Section 10, *Coordination of Benefits (COB)* does not apply to covered Prescription Drugs as described in this section. Benefits for Prescription Drugs will not be coordinated with those of any other health coverage plan.

Identification Card (ID Card) – Network Pharmacy

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

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

Benefit Levels

Benefits are available for outpatient Prescription Drugs that are considered Covered Health Services.

The Plan pays Benefits at different levels for tier-1, tier-2 and tier-3 Prescription Drugs. All Prescription Drugs covered by the Plan are categorized into these three tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug, depending on its tier assignment. Since the PDL may change periodically, you can visit **www.myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card for the most current information.

Each tier is assigned a Copay, which is the amount you pay when you visit the pharmacy or order your medications through mail order. Your Copay will also depend on whether or not you visit the pharmacy or use the mail order service - see the table shown at the beginning of this section for further details. Here's how the tier system works:

- Tier-1 is your lowest Copay option. For the lowest out-of-pocket expense, you should consider tier-1 drugs if you and your Physician decide they are appropriate for your treatment.
- Tier-2 is your middle Copay option. Consider a tier-2 drug if no tier-1 drug is available to treat your condition.
- Tier-3 is your highest Copay option. The drugs in tier-3 are usually more costly. Sometimes there are alternatives available in tier-1 or tier-2.

For Prescription Drugs at a retail Network Pharmacy or mail order Network Pharmacy, you are responsible for paying the lowest of:

- the applicable Copay in addition to any Ancillary Charge, Therapeutic Class Charge, or Therapeutically Equivalent Charge;
- the Network Pharmacy's Usual and Customary Charge for the Prescription Drug; or
- the Prescription Drug Cost that UnitedHealthcare agreed to pay the Network Pharmacy.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment that applies to the applicable tier drug.

Retail

The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto **www.myuhc.com**.

To obtain your prescription from a retail pharmacy, simply present your ID card and pay the Copay and applicable Ancillary Charge. The Plan pays Benefits for certain covered Prescription Drugs:

- as written by a Physician;
- up to a consecutive 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on quantity limits;
- when a Prescription Drug is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copay that applies will reflect the number of days dispensed; and
- a one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Copay for each cycle supplied.

Note: Pharmacy Benefits apply only if your prescription is for a Covered Health Service and if prescribed by a Physician for dental services. If the Pharmacy Benefits apply to Experimental or Investigational, or Unproven Services, you are responsible for paying 100% of the cost.

Mail Order

The mail order service may allow you to purchase up to a 90-day supply of a covered maintenance drug through the Prescription Solutions Mail Order Pharmacy. Maintenance drugs help in the treatment of chronic illnesses, such as heart conditions, allergies, high blood pressure, and arthritis.

To use the mail order service, all you need to do is complete a patient profile and enclose your prescription order or refill. If you need an order form, patient profile, or if you have any questions, you can reach UnitedHealthcare at the toll-free number on your ID card.

To use the mail order service, choose the method that works best for you:

1. Call (**800) 562-6223**, 24 hours a day, 7 days a week. Keep your medication name and dosage handy. You'll also need your Physician's name and phone number. Prescription Solutions will call your Physician to get a new prescription.
2. Mail your original prescription, payment and completed order form to the address listed on the form. Write your date of birth on each prescription.
3. Your Physician can call in your prescription to (**800) 791-7658** or fax it to (**800) 491-7997**. Faxed prescriptions will only be accepted from a Physician's office.

Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received.

The Plan pays mail order Benefits for certain covered Prescription Drugs:

- as written by a Physician; and
- up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on quantity limits.

These supply limits do not apply to Specialty Prescription Drugs. Specialty Prescription Drugs from a mail order Network Pharmacy are subject to a 30-day supply limit as stated in the footnote to the Schedule limits under Covered Health Services.

You may be required to fill an initial Prescription Drug order and obtain one refill through a retail pharmacy prior to using a mail order Network Pharmacy.

Note: To maximize your benefit, ask your Physician to write your prescription order or refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copay for any prescription order or refill if you use the mail order service, regardless of the number of days' supply that is written on the order or refill. Be sure your Physician writes your mail order or refill for a 90-day supply, not a 30-day supply with three refills.

Benefits for Preventive Care Medications

Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined under *Glossary – Prescription Drugs*. You may determine whether a drug is a Preventive Care Medication through the internet at **www.myuhc.com** or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

Designated Pharmacy

If you require certain Prescription Drugs, UnitedHealthcare may direct you to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drugs.

Specialty Prescription Drugs

You may fill a prescription for Specialty Prescription Drugs up to two times at any Network Pharmacy. However, after that you will be directed to a Designated Pharmacy and if you

choose not to obtain your Specialty Prescription Drugs from a Designated Pharmacy, no Benefits will be paid and you will be responsible for paying all charges.

Please see the Prescription Drug Glossary in this section for definitions of Specialty Prescription Drug and Designated Pharmacy. Refer to the footnote in the table at the beginning of this section for details on Specialty Prescription Drug supply limits.

Want to lower your out-of-pocket Prescription Drug costs?
Consider Generic Prescription Drug Products, if you and your Physician decide they are appropriate.

Assigning Prescription Drugs to the PDL

UnitedHealthcare's Prescription Drug List (PDL) Management Committee makes the final approval of Prescription Drug placement in tiers. In its evaluation of each Prescription Drug, the PDL Management Committee takes into account a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include:

- evaluations of the place in therapy;
- relative safety and efficacy; and
- whether quantity limits or notification requirements should apply.

Economic factors may include:

- the acquisition cost of the Prescription Drug; and
- available rebates and assessments on the cost effectiveness of the Prescription Drug.

Some Prescription Drugs are more cost effective for specific indications as compared to others, therefore, a Prescription Drug may be listed on multiple tiers according to the indication for which the Prescription Drug was prescribed.

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

The PDL Management Committee may periodically change the placement of a Prescription Drug among the tiers. Placement of drugs on a higher tier will only occur twice a year; January 1 and July 1. You will be notified sixty days in advance if you are taking one of the impacted drugs. Placement of drugs on a lower tier may occur throughout the year without prior notice to you. These changes will not occur more than six times per calendar year and may occur without prior notice to you.

Prescription Drug, Prescription Drug List (PDL), and Prescription Drug List (PDL) Management Committee are defined at the end of this section.

Notification Requirements

Before certain Prescription Drugs are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to notify UnitedHealthcare. UnitedHealthcare will determine if the Prescription Drug, in accordance with UnitedHealthcare approved guidelines, is both:

- a Covered Health Service as defined by the Plan; and
- not Experimental or Investigational or Unproven, as defined in Section 14, *Glossary*.

Network Pharmacy Notification

When Prescription Drugs are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying UnitedHealthcare.

Non-Network Pharmacy Notification

When Prescription Drugs are dispensed at a Non-Network Pharmacy, you or your Physician are responsible for notifying UnitedHealthcare.

If UnitedHealthcare is not notified before the Prescription Drug is dispensed, you may pay more for that Prescription Drug order or refill. You will be required to pay for the Prescription Drug at the time of purchase. The contracted pharmacy reimbursement rates (the Prescription Drug Cost) will not be available to you at a Non-Network Pharmacy. If UnitedHealthcare is not notified before you purchase the Prescription Drug, you can request reimbursement after you receive the Prescription Drug - see Section 9, *Claims Procedures*, for information on how to file a claim.

When you submit a claim on this basis, you may pay more because you did not notify UnitedHealthcare before the Prescription Drug was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost (for Prescription Drugs from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drugs from a Non-Network Pharmacy), less the required Copayment, Ancillary Charge and any Deductible that applies.

To determine if a Prescription Drug requires notification, either visit **www.myuhc.com** or call the toll-free number on your ID card. The Prescription Drugs requiring notification are subject to UnitedHealthcare's periodic review and modification.

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

Prescription Drug Benefit Claims

For Prescription Drug claims procedures, please refer to Section 9, *Claims Procedures*.

Limitation on Selection of Pharmacies

If UnitedHealthcare determines that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, you may be required to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date UnitedHealthcare notifies you, UnitedHealthcare will select a single Network Pharmacy for you.

Quantity limits

Some Prescription Drugs are subject to quantity limits that may restrict the amount dispensed per prescription order or refill. To determine if a Prescription Drug has been assigned a maximum quantity level for dispensing, either visit **www.myuhc.com** or call the toll-free number on your ID card. Whether or not a Prescription Drug has a quantity limit is subject to UnitedHealthcare's periodic review and modification.

Note: Some products are subject to additional quantity limits based on criteria that Travis County and UnitedHealthcare have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per prescription order or refill and/or the amount dispensed per month's supply.

If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug becomes available as a Generic drug, the tier placement of the Brand-name Drug may change and an Ancillary Charge may apply. You will pay the Copay applicable for the tier to which the Prescription Drug is assigned. As a result, your Copay may change.

Special Programs

Travis County and UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced benefit based on your actions such as adherence/compliance to medication regimens. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on the back of your ID card.

Rebates and Other Discounts

UnitedHealthcare and Travis County may, at times, receive rebates from pharmaceutical companies for certain drugs on the PDL. UnitedHealthcare does not pass these rebates and other discounts on to you nor does UnitedHealthcare take them into account when determining your Copays. All rebates, less an administrative fee paid to UnitedHealthcare, are retained in the Travis County Health Benefit Fund.

UnitedHealthcare and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this Prescription Drug section. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such

arrangements are not related to this Prescription Drug section. UnitedHealthcare is not required to pass on to you, and does not pass on to you, such amounts.

Coupons, Incentives and Other Communications

UnitedHealthcare may send mailings to you or your Physician that communicate a variety of messages, including information about Prescription Drugs. These mailings may contain coupons or offers from pharmaceutical manufacturers that allow you to purchase the described Prescription Drug at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription order or refill is appropriate for your medical condition.

Exclusions - What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed under Section 8, *Exclusions* also apply to this section, except that any preexisting condition exclusion in Section 8, *Exclusions* is not applicable to this section. In addition, the following exclusions apply.

Medications that are:

1. dispensed in amounts that exceeds the quantity limit;

2. dispensed outside of the United States, except in an Emergency;

3. prescribed, dispensed or intended for use during an Inpatient Stay;

4. used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless UnitedHealthcare and Travis County have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in Section 14, *Glossary*;

5. any Prescription Drug for which payment or benefits are provided from the local, state or federal government whether or not payment or benefits are received, except as otherwise provided by law;

6. for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received;

7. prescribed for appetite suppression, and other weight loss products;

8. Pharmaceutical Products for which Benefits are provided in the medical (not in Section 15, *Prescription Drugs*) portion of the Plan;

9. Durable Medical Equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered);

10. vitamins, except for the following which require a prescription:

- prenatal vitamins;
- vitamins with fluoride; and
- single entity vitamins.

11. unit dose packaging of Prescription Drugs;

12. used for cosmetic purposes;

13. Prescription Drugs, including new Prescription Drugs or new dosage forms, that Travis County determines do not meet the definition of a Covered Health Service;

14. Prescription Drug as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed;

15. prescribed to treat infertility;

16. compounded drugs that do not contain at least one ingredient that requires a prescription order or refill and has been approved by the U.S. Food and Drug Administration; compounded drugs that are available as a similar commercially available Prescription Drug; (Compounded drugs that contain at least one ingredient that requires a prescription order or refill are assigned to Tier-3);

17. available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless Travis County has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a prescription order or refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that Travis County has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and Travis County may decide at any time to reinstate Benefits for a Prescription Drug that was previously excluded under this provision;

18. new drugs and/or new dosages, until they are reviewed and assigned to a tier by the PDL Management Committee;

19. growth hormone for children with familial short stature based on heredity and not caused by a diagnosed medical condition);

20. oral non-sedating antihistamines or a combination of antihistamines and decongestants;

21. Prescription Drugs that contain (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug;

22. Prescription Drugs that contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug; and

23. typically administered by a qualified provider or licensed health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception;

Glossary - Prescription Drugs

Ancillary Charge – a charge, in addition to the Copayment, that you are required to pay when a covered Prescription Drug is dispensed at your or the provider's request, when a chemically equivalent Prescription Drug is available on a lower tier. For Prescription Drugs from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug on the higher tier, and the Prescription Drug Charge or MAC List price of the chemically equivalent Prescription Drug available on the lower tier.

Brand-name - a Prescription Drug that is either:

- manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- identified by UnitedHealthcare as a Brand-name Drug based on available data resources including, but not limited to, Medi-Span that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by UnitedHealthcare.

Designated Pharmacy – a pharmacy that has entered into an agreement with UnitedHealthcare or with an organization contracting on its behalf, to provide specific Prescription Drugs including, but not limited to, Specialty Prescription Drugs. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug that is either:

- chemically equivalent to a Brand-name drug; or
- identified by UnitedHealthcare as a Generic Drug based on available data resources, including, but not limited to, Medi-Span that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by UnitedHealthcare.

Maximum Allowable Cost (MAC) List – a list of Generic Prescription Drugs that will be covered at a price level that the Claims Administrator establishes. This list is subject to periodic review and modification.

Network Pharmacy - a retail or mail order pharmacy that has:

- entered into an agreement with UnitedHealthcare to dispense Prescription Drugs to Covered Persons;

- agreed to accept specified reimbursement rates for Prescription Drugs; and
- been designated by UnitedHealthcare as a Network Pharmacy.

PDL - see Prescription Drug List (PDL).

PDL Management Committee - see Prescription Drug List (PDL) Management Committee.

Predominant Reimbursement Rate – the amount the Plan will pay to reimburse you for a Prescription Drug Product that is dispensed at a Non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug dispensed at a Non-Network Pharmacy includes a dispensing fee and any applicable sales tax. UnitedHealthcare calculates the Predominant Reimbursement Rate using its Prescription Drug Cost that applies for that particular Prescription Drug at most Network Pharmacies.

Prescription Drug - a medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, only be dispensed using a prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of this Plan, Prescription Drugs include:

- inhalers (with spacers);
- insulin;
- the following diabetic supplies:
    - standard insulin syringes with needles;
    - blood testing strips - glucose;
    - urine testing strips - glucose;
    - ketone testing strips and tablets;
    - lancets and lancet devices;
    - insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets; and
    - glucose monitors.

Prescription Drug Cost – the rate UnitedHealthcare has agreed to pay its Network Pharmacies, including a dispensing fee and any applicable sales tax, for a Prescription Drug dispensed at a Network Pharmacy.

Prescription Drug List (PDL) - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration*. This list is subject to periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug has been assigned by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto **www.myuhc.com**.

Prescription Drug List (PDL) Management Committee - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

Preventive Care Medications – the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Prescription Drug Deductible or Specialty Prescription Drug Annual Deductible) as required by applicable law under any of the following:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; or
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

Specialty Prescription Drug - Prescription Drug that is generally high cost, self-injectable, oral or inhaled biotechnology drug used to treat patients with certain illnesses. For more information, visit **myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card.

Therapeutic Class – a group or category of Prescription Drug with similar uses and/or actions.

Therapeutically Equivalent – when Prescription Drugs can be expected to produce essentially the same therapeutic outcome and toxicity.

Usual and Customary Charge – the usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

SECTION 16 - IMPORTANT ADMINISTRATIVE INFORMATION

What this section includes:
- Plan administrative information.

This section includes information on the administration of the medical Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Additional Plan Description

Claims Administrator: The claims administrator is the company which provides certain administrative services for the Plan Benefits described in this Summary Plan Description. That company is UnitedHealthcare (also known as United HealthCare Services, Inc.) and its affiliates.

United HealthCare Services, Inc.
Attn: Claims
185 Asylum Street
Hartford, CT 06103-3408

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

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as UnitedHealthcare. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by United HealthCare Services, Inc. The named fiduciary of Plan is Travis County, the Plan Sponsor.

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

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

UnitedHealthcare generally allows the designation of a Primary Care Provider. You have the right to designate any Primary Care Provider who participates in UnitedHealthcare's network and who is available to accept you or your family members. For information on how to select a Primary Care Provider, and for a list of the participating Primary Care Providers, contact UnitedHealthcare at the number on the back of your ID card.

For children, you may designate a pediatrician as the Primary Care Provider.

You do not need prior authorization from UnitedHealthcare or from any other person (including a Primary Care Provider) to obtain access to obstetrical or gynecological care from a health care professional in UnitedHealthcare's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact UnitedHealthcare at the number on the back of your ID card.

ATTACHMENT II - PROTECTED HEALTH INFORMATION NOTICES

Travis County Employee Health Benefit Fund Plan Document

The Use and Disclosure of Protected Health Information and Security of Electronic Protected Health Information

Under the federal privacy regulations enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your health plans are required to protect the confidentiality of your Protected Health Information. Protected Health Information (PHI) is individually identifiable health information related to your condition, services provided to you, or payments made for your care, which is created or received by a health plan, a health care clearinghouse, or a health care provider that electronically transmits such information. Travis County Employee Health Benefit Fund and Travis County, Texas will not use or disclose health information protected by HIPAA, except for treatment, payment, health plan operations (collectively known as "TPO"), as permitted or required by other state and federal law, or to business associates to help administer the Plan.

All disclosures of the PHI by a health insurance issuer or HMO to the Plan Sponsor will comply with the restrictions and requirements set forth in the Plan and in the "504" provisions.

The Plan may not disclose and may not permit a health insurance issuer or HMO to disclose members' PHI to the Plan Sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of

- Obtaining premium bids from health plans for providing health insurance coverage under the Plan, or
- Modifying, amending, or terminating the Plan.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the "504" provisions.

Further, Travis County, Texas will take reasonable steps to ensure that any use or disclosure is the minimum necessary to accomplish the task.

In addition, under the federal security regulations enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your health plans are required to safeguard the confidentiality and ensure the integrity and availability of your Electronic Protected Health Information. Electronic Protected Health Information (ePHI) is PHI that is maintained or transmitted in electronic form. Travis County Employee Health Benefit Fund and Travis County, Texas will reasonably and appropriately safeguard ePHI created, received, maintained, or transmitted to or by Travis County, Texas on behalf of the Plan.

The Plan and Travis County, Texas exchange information to coordinate your Plan coverage. Travis County, Texas agrees that it will:

- Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;
- Ensure that any agents, including subcontractors, to whom it provides PHI received from Travis County Employee Health Benefit Fund agree to the same restrictions and conditions that apply to Travis County, Texas with respect to such information;
- Not use or disclose PHI for employment-related actions and decisions;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of Travis County, Texas;
- Notify the Benefit Manager of any improper use or disclosure of PHI of which it becomes aware;
- Make PHI available to an individual based on HIPAA's access requirements;
- Make PHI available for amendment and incorporate any changes to PHI based on HIPAA's amendment requirements;
- Make available the information required to provide an accounting of disclosures of PHI;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with HIPAA;
- Ensure adequate separation between the Plan and other operations of Plan Sponsor as required by HIPAA; and
- If feasible, return or destroy all PHI received from Plan that other operations of Travis County, Texas still maintains in any form and retain no copies of such PHI when no longer needed for the specified disclosure purpose. If return or destruction is not feasible, Travis County, Texas will limit further uses and disclosures to those purposes that make the return or destruction infeasible.

In order to receive ePHI from the Plan for its other operations, Travis County, Texas agrees that it will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that any other operation of Travis County, Texas creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that access to, and use and disclosure of ePHI by the employees or classes of employees described in this Plan document is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom Travis County, Texas provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

- Report to the Benefit Manger any security incident of which Travis County, Texas becomes aware.

Only the following classes of employees under the control of Travis County, Texas may have access to PHI or ePHI:

- Designated HR Benefits Personnel. This class also includes those persons responsible for interacting with members, employees, providers, business associates, and others in resolving eligibility, benefits, claims, coordination of benefits, and other plan administration issues.
- Information Technology Administrators, Operations Support Personnel and Technical Support Personnel. These personnel include personnel responsible for creating and maintaining plan content, information, data sets and applications, and other related information Assets. These personnel may also be responsible for organization web sites, connectivity within the organization's networks, electronic mail, and connectivity with external networks.
- Clerical Personnel. These personnel include mail personnel, secretarial support, and others responsible for document handling and preparation.
- Supervision. Supervisors include only those persons who directly supervise other direct users of PHI.
- Financial Analysts for Health Plan.
- Benefit Administrator. This class also includes those responsible for preparing and submitting information to potential business associates and in managing performance of existing associates.

These employees may only have access to, and use and disclose, PHI for purposes of the plan administrative functions described in this Plan document.

If you believe your rights under HIPAA have been violated, you have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services. Travis County, Texas has provided a mechanism for resolving issues of noncompliance by employees described above who have access to PHI or ePHI. For more information about resolving issues of non-compliance, contract the Benefit Manager at the Human Resources Management Department, Suite 420, 700 Lavaca Street, Austin, Texas, 78701, (512) 854-9165. All other terms, provisions, and conditions shown in your Health Benefits Plan Booklet will continue to apply. All other terms, provisions and conditions shown in this Summary Plan Description will continue to apply.

ATTACHMENT III - EARLY RETIREE REINSURANCE PROGRAM (ERRP) NOTICE

You are a Plan Member, or are being offered the opportunity to enroll as a Plan Member, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your Plan Sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in Plan Members' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the Plan Sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a Plan Member, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and the Plan Sponsor chooses to use the reimbursements for this purpose.

The Plan Sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are Members in this plan.

ADDENDUM - UNITEDHEALTH ALLIES

Introduction

This Addendum to the Summary Plan Description provides discounts for select non-Covered Health Services from Physicians and health care professionals.

When the words "you" and "your" are used the Addendum is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

Important:
UnitedHealth Allies is not a health insurance plan. You are responsible for the full cost of any services purchased, minus the applicable discount. Always use your health insurance plan for Covered Health Services described in the Summary Plan Description (see Section 5, *Plan Highlights*) when a benefit is available.

What is UnitedHealth Allies?

UnitedHealth Allies is a health value program that offers savings on certain products and services that are not Covered Health Services under your health plan.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through UnitedHealth Allies are available to Covered Persons as defined in the Summary Plan Description in Section 14, *Glossary*.

Selecting a Discounted Product or Service

A list of available discounted products or services can be viewed online at **www.healthallies.com** or by calling the number on the back of your ID card.

After selecting a health care professional and product or service, reserve the preferred rate and print the rate confirmation letter. If you have reserved a product or service with a customer service representative, the rate confirmation letter will be faxed or mailed to you.

Important:
You must present the rate confirmation at the time of receiving the product or service in order to receive the discount.

Visiting Your Selected Health Care Professional

After reserving a preferred rate, make an appointment directly with the health care professional. Your appointment must be within ninety (90) days of the date on your rate confirmation letter.

Present the rate confirmation and your ID card at the time you receive the service. You will be required to pay the preferred rate directly to the health care professional at the time the service is received.

Additional UnitedHealth Allies Information

Additional information on the UnitedHealth Allies program can be obtained online at **www.healthallies.com** or by calling the toll-free phone number on the back of your ID card.

Combined

Summary Plan Description (SPD)

Choice Plan for Travis County Employees
and
Choice Plan for Travis County Retirees

Group Number: 701254
Effective Date: October 1, 2009

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Introduction

This Summary Plan Description ("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 Amendments.

We especially encourage you to review the following:

- Benefit limitations in Section 1: What's Covered--Benefits and Section 2: What's Not Covered--Exclusions.
- Section 9: General Legal Provisions.

Many of the sections of the SPD are related to other sections. You may not have all of the information you need by reading just one section. You should call the Claims Administrator if you have questions about the limits of the coverage available to you.

Your Physician does not have a copy of your SPD and is not responsible for knowing or communicating your Benefits.

Note: This SPD is a combined description for multiple plans. The SPD describes the benefits offered in the following plans: Choice Plan for Travis County Employees and Choice Plan for Travis County Retirees.

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

Information about Defined Terms

Certain capitalized words have the special meanings stated in Section 10: Glossary of Defined Terms. Refer to Section 10 for a clearer understanding of your SPD.

"We", "us", and "our" in this document refer to the Plan Sponsor.

"You" and "your" refer to people who are Covered Persons as 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 your contribution.

Customer Service and Claims Submittal

Customer Service Representative (for questions about Coverage or procedures): is shown on your ID card.

Claims Administrator for Prior Notification: is shown on your ID card.

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

Claims Submittal Address:
United HealthCare Insurance Company
Attn: Claims
P.O. Box 30555
Salt Lake City, Utah 84130-0555

Requests for Review of Denied Claims and Notice of Complaints:
United HealthCare Insurance Company
P.O. Box 30432
Salt Lake City, Utah 84130-0432

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

Section 1: What's Covered--Benefits

This section provides you with information about:

- Accessing Benefits.
- Copayments, CoInsurance, Eligible Expenses.
- Annual Deductible, Out-of-Pocket Maximum, Maximum Plan Benefit.
- Covered Health Services.
- Covered Health Services that require you or your provider to notify the Claims Administrator before you receive them.

Accessing Benefits

You must see a Network Physician to obtain Network Benefits.

You must show your identification card "ID card" every time you request health care services from a Network provider. If you do not show your ID card, Network providers may bill you for the entire cost of the services you receive. For details about Network Benefits, see Section 3: Obtaining Benefits.

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

- Covered Health Services are received after the Plan is in effect.
- Covered Health Services are received before 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 in the Plan.

Copayment and CoInsurance

Copayment and CoInsurance are the amounts you pay each time you receive certain Covered Health Services.

CoInsurance – the charge you are required to pay for specified Covered Health Services. CoInsurance is calculated as a percentage of Eligible Expenses.

Copayment – the charge you are required to pay for specified Covered Health Services. A Copayment is a set dollar amount.

Copayment and CoInsurance amounts are listed on the following pages next to the description for each Covered Health Service.

Eligible Expenses

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

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

When you receive Covered Health Services from Network providers, you are not responsible for any difference between the

Eligible Expenses and the amount the provider bills. When you receive Covered Health Services from Non-Network providers, you are responsible for paying, directly to the Non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses.

Out-of-Pocket Maximum

Out-of-Pocket Maximum – is the maximum amount you pay for Annual Deductible and CoInsurance every calendar year. Benefits with Copayments will never be payable at 100%. Where applicable, you will always pay a Copayment even after you have met your Out-of-Pocket Maximum.

Once you reach the Out-of-Pocket Maximum for Network Benefits, we will pay Network Benefits for Covered Health Services at 100% CoInsurance for Eligible Expenses during the rest of that calendar year.

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

- Any charges for non-Covered Health Services;
- Copayments for Covered Health Services available under this SPD or any Rider.
- The amount of any Benefits that is reduced if you don't notify the Claims Administrator as described in Section 1: What's Covered--Benefits.
- Charges that exceed Eligible Expenses.

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

- Any charges for non-Covered Health Services.
- Charges that exceed Eligible Expenses.
- The amount of any Benefits that is reduced if you don't notify the Claims Administrator as described in Section 1: What's Covered--Benefits.
- Copayments for Covered Health Services available under this SPD or any Rider.

Copayments for Covered Health Services in Section 1: What's Covered--Benefits do not apply to the Out-of-Pocket Maximum.

Requirement to Notify the Claims Administrator

In general, Network providers are responsible for notifying the Claims Administrator before they provide specified services to you. There are some Network Benefits, however, for which you must notify the Claims Administrator before you receive certain Covered Health Services.

For emergency services, notify the Claims Administrator as soon as possible, but at least one business day before post-Emergency treatment begins.

For Mental Health and Substance Abuse Benefits, you must get authorization in advance of any inpatient treatment through the Mental Health/Substance Abuse Designee by calling the telephone number on the back of your ID card. If you don't notify the Mental Health/Substance Abuse Designee, we will not pay any Benefits and you will be responsible for paying all charges.

When you receive specified Covered Health Services from Non-Network providers, you must also notify the Claims Administrator before you receive some specified Covered Health Services.

To ensure prompt and accurate payment of your claim as a Network Benefit, notify the Claims Administrator within two business days or as soon as possible after you receive outpatient Emergency Health Services at a Non-Network Hospital or Alternate Facility.

Services for which you must provide prior notification and the minimum notice period appear in the table labeled Benefit Information. See the heading **Notification Required**.

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

When you choose to receive services from Non-Network providers, confirm with the Claims Administrator that the services you plan to receive are Covered Health Services, even if not indicated in the table labeled Benefit Information. See the heading **Notification Required**, because the circumstances surrounding some procedures may affect whether the procedure is a Covered Health Service and whether it will be excluded. By calling before you receive treatment, you can determine if the service is subject to limitations or exclusions such as:

- The Cosmetic Procedures exclusion. Examples of procedures that may or may not be considered Cosmetic include: breast reduction and reconstruction (except 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.

If you don't notify the Claims Administrator, Benefits will be reduced by $250 for each hospital inpatient stay, each nursing facility stay, each reconstructive procedure, each treatment plan or single item of Durable Medical Equipment or prosthetic device; however, the reduction in Benefits will not exceed Eligible Expenses for the Covered Health Services. This reduction does not help you to meet the Annual Deductible or the Out of Pocket Maximum.

Benefits will not be reduced for the outpatient Emergency Health Services.

If you do not notify the Claims Administrator about Transplant Procedures, you will be responsible for paying all charges and Network Benefits will not be paid. Non-Network Benefits will not be available.

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.

Special Note About Experimental, Investigational or Unproven Service

If you have a Sickness or condition that is likely to cause death within one year of your request for treatment, we and the Claims Administrator may, in our discretion, determine that an Experimental, Investigational or Unproven Service meets the definition of a Covered Health Service for that Sickness or condition if we and the Claims Administrator 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.

Special Note About Medicare

If you are eligible for Medicare please refer to Medicare Eligibility information in Section 9: General Legal Provisions.

Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services in a calendar year before we begin paying Benefits for Covered Health Services to which CoInsurance applies in that calendar year. The actual amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. See Eligible Expenses, in Section 10: Glossary of Defined Terms.	No Annual Deductible
Out-of-Pocket Maximum	The maximum you pay, out of your pocket, in a calendar year for CoInsurance. For a complete discussion of Out-of-Pocket Maximum, see page 3 in this Section 1. The Out-of-Pocket Maximum does include the Annual Deductible.	$1,000 per Covered Person per calendar year.
Maximum Plan Benefit	The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Plan or any other Plan of Plan Sponsor.	$2,000,000 per Covered Person.

Benefit Information

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?
1. Acupuncture Services must be provided by a person who specializes in acupuncture and is licensed by the appropriate authority for regulating acupuncture within the jurisdiction in which the services are provided and is operating within the scope of that license. Services must be for one of the following conditions: • Post operative nausea • Nausea due to chemotherapy • Nausea during the first trimester of pregnancy • Treatment of pain Each treatment is limited to three modalities during a visit. Covered Services are limited to a combined total of 30 visits each Calendar Year.	**For a Primary Care Provider** $25 per visit **For a Non-Primary Care Provider** $40 per visit	No
2. Ambulance Services - Emergency and Medically Appropriate Only Emergency ambulance services by a licensed ambulance service whether transported or not. Transport is to the nearest Hospital that is medically equipped to perform the needed emergency health services. Ambulance services when required due to a medical condition.	0%	No

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?
3. Cancer Resource Services We will arrange for access to certain of our Network providers that participate in the Cancer Resource Services Program for the provision of oncology services. We may refer you to Cancer Resource Services, or you may self refer to Cancer Resource Services by calling 866-936-6002. The oncology services include Covered Health Services and supplies rendered for the treatment of a condition that has a primary or suspected diagnosis relating to cancer. In order to receive Benefits under this program, Cancer Resource Services must provide the proper notification to the Network provider performing the services. This is true even if you self refer to a Network provider participating in the program. When these services are not performed in a Cancer Resource Services facility, Benefits will be paid the same as Benefits for Hospital-Inpatient Stay, Outpatient Surgery, Diagnostic and Therapeutic Services, Physician's Office Services, and Professional Fees for Surgical and Medical Services stated in this Section 1: What's Covered--Benefits.	0% **Notification Required** Cancer Resource Services must be called.	No

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?
4. Colonoscopies and other Scopies Diagnostic and therapeutic scopic procedures and related services including laboratory charges received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office. Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy. Surgical scopic procedures, which are for the purpose of performing surgery. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.	0%	No

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?
5. Dental Services - Accident only Dental services when all of the following are true: • Treatment is necessary because of accidental damage. • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D.". • The dental damage is severe enough that initial contact with a Physician or dentist occurred within 96 hours of the accident. Benefits are available only for treatment of a sound, natural tooth, restored teeth, and prosthesis in good condition to be restored to pre-accident condition. The Physician or dentist must certify to the pre-accident condition of the injured tooth. Dental services for final treatment to repair the damage must be both started within three months of the accident and completed within 12 months of the accident. Oral surgery, full or partial dentures, fixed bridge work, prompt repair to natural teeth, and crowns are covered **only** if needed because of accidental injury and the accident occurred while the Covered Person is covered by this Plan. The least costly, dentally necessary treatment will be considered a Covered Benefit in these circumstances. Dental damage that occurs as a result of normal activities of daily living, such as chewing or eating ice, is not considered an "accident" and repairs to teeth that are injured as a result of such activities are not covered.	0% **Notification Required** Notify the Claims Administrator, and ask for Care Coordination℠, as soon as possible, but at least one business day before post-Emergency treatment begins.	No

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?
6. Disposable Medical Supplies Disposable Medical Supplies that meet each of the following criteria: • Ordered or provided by a Physician for outpatient use. • Used for medical purposes to treat a Sickness, Injury or their symptoms. • Not generally useful to a person in the absence of a Sickness, Injury or their symptoms. • Appropriate for use in the home. • Available through a medical supplier and not generally available in grocery or general merchandise stores. Examples of Disposable Medical Supplies include the following: • Two medically appropriate pairs of elastic stockings each year, • Diabetic supplies including the following: — Standard insulin syringes with needles, — Blood testing strips – glucose, — Urine testing strips – glucose, — Ketone testing strips and tablets, — Lancets and lancet devices, — Glucometers (every two years). • Inhaler spacers. • Colostomy bags and supplies. • Intravenous tubing. • Respiratory therapy supplies.	0% ***Diabetic Supplies*** 0%	No No

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?
• Ace bandages. • Gauze and dressings when used with Durable Medical Equipment.		
7. Durable Medical Equipment Durable Medical Equipment that meets each of the following criteria: • Ordered or provided by a Physician for outpatient use. • Used for medical purposes to treat a Sickness, Injury or their symptoms. • Not generally useful to a person in the absence of Sickness, Injury or their symptoms. • Appropriate for use in the home. • Capable of withstanding repeated use. • Not consumable or disposable. • Available through a medical supplier and not generally available in grocery or general merchandise stores. Examples of Durable Medical Equipment include: • Equipment to assist mobility, such as a standard wheelchair. • A standard Hospital-type bed. • Oxygen and the rental of equipment to administer oxygen(including tubing, connectors and masks).	0% **Notification Required** Pre-Notification required for any Durable Medical Equipment over $1,000 whether for purchase or rental.	No

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?

- Delivery pumps for tube feedings (including tubing and connectors).
- Braces that stabilize an Injured body part and braces to treat curvature of the spine. Orthotic devices that straighten or change the shape of a body part such as arm, leg, neck and back braces are covered, including necessary adjustments to shoes to accommodate braces. However, orthotic shoes or shoe inserts unless attached to a brace and dental braces are excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure.

We provide Benefits only for a single purchase (including repair/ replacement) of a type of Durable Medical Equipment once every three calendar years unless an additional purchase is required by a change in your physical condition. If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are only available for the most cost-effective piece of equipment.

We and the Claims Administrator will decide if the equipment should be purchased or rented. To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor the Claims Administrator identifies.

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?
8. Emergency Health Services Services that are required to stabilize or initiate treatment provided by or under the direction of a Physician in an Emergency. An **Emergency** is a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which arises suddenly and in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid placing the patient's life or health in serious jeopardy, causing serious impairment to bodily functions, serious dysfunction of any bodily organ or part or in the case of a pregnant woman serious disfigurement or serious jeopardy to the health of a fetus. Emergency Health Services are always paid as a Network Benefit. If you seek Emergency care at a Non-Network facility, you are not required to pay any difference between Eligible Expenses and the amount the provider bills.	$100 per visit which is waived if an Inpatient Stay is required. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility. **Notification Required** Notify the Claims Administrator, and ask for Care Coordination℠, on the day of admission or within one business day, or as soon as reasonably possible, but only if an Inpatient Stay is required. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the Non-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Benefits will not be available.	No

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?
9. Eye Examinations and Vision Therapy Eye examinations received from a health care provider in the provider's office. Network Benefits include one routine vision exam, including refraction, to detect vision impairment by a Network Provider each calendar year. Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses. Vision therapy (Synonyms include: eye exercise therapy, optometric visual (or vision) therapy, vision training, orthoptic training and pleoptic training)	$40	No
10. Home Health Care Services received from a Home Health Agency, a program or organization authorized by law to provide health care services in the home, that are both: • Ordered by a Physician. • Provided by or supervised by a registered nurse in your home. Skilled care includes skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true: • Care is 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. • Care is not delivered to assist with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.	0% Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and skilled care is required.	No

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?
• Care requires clinical training to be delivered safely and effectively. • It is not Custodial Care. Home Health Care includes temporary or part-time care by a home health aide. 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 is not considered "skilled" simply because there is not an available caregiver.		
11. Hospice Care Hospice care is an integrated program that provides comfort and support services for the terminally ill who are not expected to live more than six months. 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 recommended by a Physician and received from a licensed hospice agency. Contact the Claims Administrator at the telephone number on your ID Card for more information about guidelines for hospice care.	0%	No

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?
12. Hospital - Inpatient Stay 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 with two or more beds or a private room only if a Semi-private Room is not available or a private room is appropriate in terms of generally accepted medical practice. Benefits for Physician services are described under Professional Fees for Surgical and Medical Services.	$100 per Inpatient Stay	No
13. Injections received in a Physician's Office This Benefit is available when only injections are received in a Physician's office and no other health service is received. When other health services are received, Benefits are described under Physician's Office Services below. Allergists are considered as primary care.	***For a Primary Care Provider**** $25 ***For a Non-Primary Care Provider**** $40 *No Copayment applies when there is no Physician charge	No No

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?

14. Maternity Services

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

The initial visit to the Network obstetrician who diagnoses pregnancy and is primarily responsible for the Covered Person's maternity care is subject to a Physician's Office Visit Copayment. This Copayment covers all subsequent routine prenatal and post-natal office visits to that Network Physician. All tests after the diagnoses that are recommended by that Network Physician are subject to applicable deductibles and CoInsurance. The Current Procedural Terminology is the guideline for determining whether the procedure is routine or a special service.

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 before the anticipated childbirth.

Copayment and CoInsurance are determined by the type of maternity service and are the same as for other Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.

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

We will pay Benefits for an Inpatient Stay of:

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

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

Examples of additional Covered Services related to pregnancy are:

- Birth Center Services including room and board, anesthetics.
- Nurse-Midwife services by a licensed or certified Nurse-Midwife.
- Routine Well Baby care before the mother is released from the hospital including nursery care, circumcision by a surgeon and Physician services when the baby is healthy.

Services for a healthy new born child during the initial hospital stay if the baby leaves the hospital when the mother is released are covered as part of the mother's pregnancy benefits. Services for a new born child during the initial hospital stay when the new born is not healthy or is not able to leave the hospital when the mother is released are covered as benefits for the child, not as the mother's pregnancy benefits.

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?
15. Mental Health and Substance Abuse Services - Outpatient Mental Health Services and Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including: • Mental health, substance abuse and chemical dependency evaluations and assessment. • Diagnosis. • Treatment planning. • Referral services. • Medication management. • Short-term individual, family and group therapeutic services (including intensive outpatient therapy). • Crisis intervention. Referrals to a Mental Health/Substance Abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Network Benefits for outpatient Mental Health and Substance Abuse Services. Mental Health Services and/or Substance Abuse Services are limited to a combined total of 60 visits per calendar year.	***For Masters and Ph.D. level Counselors*** $25 per individual visit; ***For Psychiatrists*** $40 per individual visit;	No No

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?
16. Mental Health Services - Inpatient and Intermediate Mental Health Services received on an inpatient or intermediate care basis in a Hospital or an Alternate Facility. The Mental Health/Substance Abuse Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. At the discretion of the Mental Health/Substance Abuse Designee, two sessions of intermediate care (such as partial hospitalization) may be substituted for one inpatient day. Network Benefits for Mental Health Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. For Network Benefits, referrals to a Mental Health provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for inpatient/intermediate Mental Health Services.	$100 per Inpatient Stay **Notification Required** Mental Health/ Substance Abuse Designee must approve Benefits in advance of any treatment.	No

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?
17. Substance Abuse Services - Inpatient and Intermediate Substance Abuse Services received on an inpatient or intermediate care basis in a Hospital or an Alternate Facility. Benefits include detoxification from abusive chemicals or substances that is limited to physical detoxification when appropriate to protect your physical health and well-being. The Mental Health/Substance Abuse Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. At the discretion of the Mental Health/Substance Abuse Designee, two sessions of intermediate care (such as partial hospitalization) may be substituted for one inpatient day. Network Benefits for Substance Abuse Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. For Network Benefits, referrals to a Substance Abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee about Benefits for inpatient/intermediate Substance Abuse Services. Benefits for Substance Abuse Services are limited to two admissions of 30 days during a lifetime.	$100 per Inpatient Stay **Notification Required** Mental Health/ Substance Abuse Designee must approve Benefits in advance of any treatment.	No

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?
18. Outpatient Surgery ***Outpatient Surgery-Facility*** Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility includes only the facility charge and the charge for required Hospital-based professional services, supplies and equipment. Benefits for the surgeon fees related to outpatient surgery are described under Professional Fees for Surgical and Medical Services. ***Outpatient Surgery-Office*** When these services are performed in a Physician's office, Benefits are described under Physician's Office Services below.	$25 per surgical procedure	No
19. Outpatient Diagnostic Services Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including: • Lab. • Radiology/X-ray. • Mammography. • CT scans, PET scans, MRI, and nuclear medicine. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a Physician's office, Benefits are described under Physician's Office Services below.	0%	No

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?
20. Outpatient Therapeutic Services Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a Physician's office, Benefits are described under Physician's Office Services below.	0% **Notification Required** Notify the Claims Administrator, and ask for Care Coordination℠, at least one day before dialysis begins	No
21. Physician's Office Services **Physicians may be Primary Care or Non-Primary Care. The areas of Primary Care include:** • General Practice • Family Practice • Pediatrics • Internal medicine • Allergy and Immunology • Obstetrics • Gynecology • Chiropractic medicine • Licensed professional counseling (Masters or Ph.D. level) • Licensed clinical social work (Masters or Ph.D. level) • Psychology (Masters or Ph.D. level) **All other providers are Non-Primary Care providers.**	**For a Primary Care Provider*** $25 per visit **For a Non-Primary Care Provider*** $40 per visit *No Copayment applies when there is no Physician charge	No No

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?

Covered Health Services for the diagnosis and treatment of a Sickness or Injury received in a Physician's office.

Covered Health Services for preventive medical care. Preventive medical care includes:

- Voluntary family planning including contraceptive drugs, services and devices like:
  - — Intrauterine devices and related Physician charges;
  - — Physician services related to diaphragm fitting;
  - — Voluntary sterilization by either vasectomy or tubal ligation (diaphragm and oral contraceptive costs are covered under Prescription Drug benefits). For exclusions, see Section 2.
- Well-baby and well-child care, including PKU testing.
- One routine physical examination for each Covered Person each calendar year.
- Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment. See Eye Examinations earlier in this section.)
- Immunizations.
- Pre-natal and post natal care.
- One well woman examination each calendar year including:
  - — Breast examination and mammogram;
  - — Pelvic examination;
  - — Pap smear.

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?
22. Professional Fees for Surgical and Medical Services Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls. When these services are performed in a Physician's office, Benefits are described under Physician's Office Services above.	0%	No
23. Prosthetic Devices External prosthetic devices that replace a limb or an external body part, limited to: • Artificial arms, legs, feet and hands. • Artificial eyes, ears and noses. • Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm. If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device. The prosthetic device must be ordered or provided by, or under the direction of a Physician. Except for items required by the Women's Health and Cancer Rights Act of 1998, Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every three calendar years unless required by physical change in patient's condition.	0%	No

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?
24. Reconstructive Procedures Services for reconstructive surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiological function. Changes or improvements in physical appearance as a result of a reconstructive procedure do not classify it as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves the function of a body part. Cosmetic Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiological function are excluded from coverage. Psychological consequences or socially avoidant behavior to a Covered Person as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve the consequences or behavior as a reconstructive procedure. Benefits for reconstructive surgery include removal of scar tissue on the neck, face, or head if the scar tissue is due to Sickness or accidental Injury, breast reconstruction following a necessary mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women's Health and Cancer Rights Act of 1998, including 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.	Copayment are determined by the type of service and are the same as for other Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.	

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?
25. Rehabilitation Services - Outpatient Therapy Short-term outpatient rehabilitation services for: • Physical therapy (limited to three modalities during a visit). • Occupational therapy. • Speech therapy. • Pulmonary rehabilitation therapy. • Cardiac rehabilitation therapy. Rehabilitation services must be performed by a licensed therapy provider in accordance with a written treatment plan, 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. We will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from a defined organic sickness, autism, neurological deficit, congenital anomaly or bodily damage not resulting from physical illness, disease, pregnancy, mental illness, or substance abuse.	$5 per visit for the first 20 visits. After the 20th visit, $25 per visit.	No

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?
26. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room with two or more beds or a private room only if a Semi-private Room is not available or a private room is necessary in terms of generally accepted medical practice. 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. Benefits are limited to a combined total of 60 days per calendar year.	$100 per Inpatient Stay * *No Copayment applies if you are transferred to a Skilled Nursing Facility or Inpatient Rehabilitation Facility directly from an acute facility.	No
27. Spinal Treatment A Spinal Treatment is using manual or mechanical means to detect or correct subluxation in the body to remove nerve interface or its effects. The interference must result from or relate to distortion, misalignment or subluxation of or in the vertebral column. Benefits for Spinal Treatment when provided by a Spinal Treatment provider in the provider's office. Benefits include diagnosis and related services and are limited to three modalities of treatment per day. Benefits for Spinal Treatment are limited to a combined total of 30 visits per calendar year.	$25 per visit	No

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?
28. Transplantation Services 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. The search for bone marrow/stem cell from a donor who is not biologically related to the patient is 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. • Cornea transplants that are provided by a Network Physician at a Network Hospital.	0% **Notification Required** Notify the Claims Administrator, and ask for Care Coordination℠, at least seven (7) working days before the evaluation, donor search, organ procurement, and transplant or as soon as the possibility of a transplant arises (and before a pre-transplantation evaluation is performed at a transplant center).	No

For cornea transplants, Benefits will be paid at the same level as Professional Fees for Surgical and Medical Services, Outpatient Surgery, Diagnostic and Therapeutic Services, and Hospital - Inpatient Stay rather than as described in this section "Transplantation Services."

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage. Contact the Claims Administrator at the telephone number on your ID card for information about the specific guidelines about Benefits for transplant services.

Transportation and Lodging
For all Covered Transplantation Services

Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows if the transplant recipient resides more than 50 miles from the Facility:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
- Eligible Expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $100 per person, up to $200 for two people.
- If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging and meal expenses are paid at a per diem rate of up to $100 per person, up to $300 for three people.

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?
The Claims Administrator will assist the patient and family with travel and lodging arrangements. There is a combined overall lifetime maximum Benefit of $10,000 per Covered Person for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures.		
29. Urgent Care Center Services Covered Health Services received at an 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. 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.	$25 per visit	No

Section 2: What's Not Covered--Exclusions

This section contains information about:

- How headings are used in this section.
- Medical services that are not covered.

How We Use Headings in this Section

To help you find specific exclusions more easily, we use 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 the service is recommended or prescribed by a Physician or is the only available treatment for your condition.

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

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

A. Alternative Treatments

1. Acupressure.
2. Aroma therapy.
3. Hypnotism.
4. Massage Therapy.
5. Rolfing.
6. Ecological or environmental medicine, diagnosis or treatment.
7. Herbal medicine, holistic or homeopathic care, including drugs.
8. 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.
7. Membership costs for health clubs, weight loss clinics, and similar programs.
8. Private Duty Nursing Care as an Inpatient.

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

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, except if allowed in Section 1: What's Covered--Benefits under the heading Dental Services - Accident only.
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. (Prescription Drugs are covered under the Attached Rider.)
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.

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

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.

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 under Section 10 Glossary of Defined Terms.

If a Covered Person has a condition which 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 Experimental, Investigational or Unproven Service meets the definition of a Covered Health Service for the condition if the Claims Administrator determines that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

F. Foot Care, Unless Due to Severe Systemic Disease

1. Routine foot care (including the cutting or removal of corns and calluses). Hygienic and preventive maintenance foot care. Examples include the following:
   - Nail trimming, cutting, or debriding.
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

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— Other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.

2. Treatment of flat feet.
3. Treatment of subluxation of the foot.
4. Shoe orthotics unless attached to a brace.

G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Non-prescribed medical supplies and disposable supplies such as more than two medically appropriate stockings each year.

H. Mental Health/Substance Abuse

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.
2. Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention.
3. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis which are not listed in the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.
4. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.
5. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
6. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee.
7. Non-Network Residential treatment services unless multi-disciplinary treatment is required for the diagnosis or use of a network facility is not practicable due to the unusual circumstances of the patient and the diagnosis.
8. Services of a pastoral counselor.
9. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following:
   — Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
   — Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
   — Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
   — Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time.

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

I. Nutrition

1. Megavitamin and nutrition based therapy, chelation therapy, except to treat heavy metal poisoning.
2. Nutritional counseling for either individuals or groups unless due to diabetes or a cardiac condition.
3. Nutritional and electrolyte supplements, including infant formula and donor breast milk and enteral feedings, unless enteral feeding is the only nutrition received.

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.
2. Breast reduction surgery that is determined to be a Cosmetic Procedure.
3. Prophylactic removal of breast, replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure or prophylactic removal of breast implant unless medically appropriate.
   Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed a necessary mastectomy. See Reconstructive Procedures in Section 1: What's Covered--Benefits.
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Special foods, food supplements, liquid diets, diet plans or any related products are excluded.
6. Wigs or toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness regardless of the reason for the hair loss.

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

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 ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility unless it is a center of excellence, when that Physician or other provider:
   - — Has not been actively involved in your medical care prior to ordering the service, or
   - — Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography testing.

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L. Reproduction Treatment

1. Health services and associated expenses for infertility treatments.
2. Surrogate parenting.
3. The reversal of voluntary sterilization.
4. Procedures which facilitate a pregnancy but do not treat the cause of infertility, such as in vitro fertilization, artificial insemination, embryo transfer, gamete intrafallopian transfer, zygote intrafallopian transfer, and tubal ovum transfer.

   This exclusion does not apply to diagnoses of infertility.

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 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.

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

2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan).
3. Health services for transplants involving mechanical or animal organs.
4. Any solid organ transplant that is performed as a treatment for cancer.
5. Any multiple organ transplants not listed as a Covered Health Service under the heading Transplantation 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 hearing aids, eye glasses or contact lenses.
2. Fitting charge for hearing aids, eye glasses or contact lenses.
3. 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.

Note: Treatment of cataracts is a Covered Health Service.

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.

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

2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
   - — Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
   - — Related to judicial or administrative proceedings or orders.
   - — Conducted for purposes of medical research.
   - — Required to obtain or maintain a license of any type.
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, except for Post Traumatic Stress Disorder.
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 except for services provided while in a confinement that began before coverage ended.
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. If a provider waives Copayments, CoInsurance and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, CoInsurance 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. Non-surgical treatment of obesity, including morbid obesity.
11. Surgical treatment of obesity even if morbidly obese with a BMI greater than 35.
12. Growth hormone therapy unless approved by Claims Administrator.
13. Sex transformation operations.
14. Custodial Care which means care that is furnished mainly to train or assist in activities of daily living, instead of providing medical treatment or that can adequately be provided by person who does not have the technical skills of a health care professional.
15. Domiciliary care.
16. Private duty nursing while confined in a facility.
17. Respite care.
18. Rest cures.
19. Psychosurgery.
20. Treatment of benign gynecomastia (abnormal breast enlargement in males).
21. Medical and surgical treatment of excessive sweating (hyperhidrosis).
22. Panniculectomy, abdominoplasty, thighplasty, brachioplasty, mastopexy, and breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reconstruction following a mastectomy as described under Reconstructive Procedures in Section 1: What's Covered—Benefits.
23. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

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24. Oral appliances for snoring.
25. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from a defined organic sickness, autism, neurological deficit, congenital anomaly or bodily damage not resulting from physical illness, disease, pregnancy, mental illness, or substance abuse.
26. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
27. Any charge for services, supplies or equipment advertised by the provider as free.
28. Any charges prohibited by federal anti-kickback or self-referral statutes.
29. Services or supplies received before a Covered Person or his or her Dependent becomes covered by this Plan.
30. Education, training, and bed and board while in an institution which is mainly a school, training institution, a place of rest or a place for the aged.
31. Charges made by a Hospital for non-acute care services that may be covered when provided by other appropriate providers for any of the following:
    a. Adult or child day care center.
    b. Ambulatory surgical center.
    c. Birth center.
    d. Half-way house.
    e. Hospice.
    f. Skilled nursing facility.
    g. Treatment center.
    h. Vocational rehabilitation center.
    i. Any other area where services are not for the acute care of sick, injured or pregnant persons.

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32. Telephone consultations.
33. Tobacco dependency.

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Section 3: ObtainingBenefits

This section includes information about:
- Obtaining Benefits.
- Emergency Health Services.

Benefits

Benefits are payable for Covered Health Services which are either of the following:

- Provided by a Network Physician, Network facility, or other Network provider.
- Emergency Health Services.
- Urgent Care Center services received outside the service area.

Benefits are not payable for Covered Health Services that are provided by Non-Network providers.

Mental Health and Substance Abuse Services must be authorized by the Mental Health/Substance Abuse Designee. See Section 1: What's Covered--Benefits under the heading for Mental Health and Substance Abuse.

Provider Network

The Claims Administrator arranges for health care providers to participate in a Network. The network of providers is subject to change. It is your responsibility to select your provider. You may check the Network providers through www.myuhc.com or verify the provider's status by calling the Claims Administrator. Before obtaining services you should always verify the Network status of a provider. A provider's status may change.

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

You might not be able to obtain services from a particular Network provider. A particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

A Network provider's agreement may not include all Covered Health Services. Some Network providers contract to provide only specified Covered Health Services. Refer to your provider directory or contact the Claims Administrator for assistance.

Care Coordination[SM]

Your Network Physician must notify the Claims Administrator about certain proposed or scheduled health services. When your Network Physician notifies the Claims Administrator, they will work together to implement the Care Coordination[SM] process and to provide you with information about additional services available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy.

Other Providers

If you have a medical condition that the Claims Administrator believes needs special services, they may direct you to another provider chosen by them. If you require specified complex Covered Health Services for which expertise is limited, the Claims Administrator may direct you to a Non-Network facility or provider.

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

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the provider chosen by the Claims Administrator.

You or your Network Physician must notify the Claims Administrator of special service needs (including, transplants or cancer treatment) that might warrant referral to a Designated Facility or a Non-Network facility or provider. If you do not notify the Claims Administrator in advance, and if you receive services from a Non-Network facility or other Non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Plan.

Health Services from Non-Network Providers Paid as Network Benefits

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

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

Non-Network Benefits Exception

You may be eligible to receive Benefits for certain Non-Network Covered Health Services paid at the Network level if you do not have access to a Network provider within a 30 mile radius of your home zip code.

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

You can check a provider's Network status by visiting www.myuhc.com or by calling the Claims Administrator at the toll-free number on your ID card. We and the Claims Administrator must approve any Benefits payable under this exception before you receive care.

Limitations on Selection of Providers

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

If you don't make a selection within 31 days of the date we notify you, the Claims Administrator will select a single Network Physician for you.

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

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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 process. The Plan Administrator or its designee will give you notice of the necessary process, along with instructions about enrolling 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 your coverage begins on the day that you are discharged from the Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

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Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Eligible Person	***Plan for Employees*** Eligible Person refers to an Eligible Employee of person 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, Eligible Employee, and Participant, see Section 10: Glossary of Defined Terms. If both spouses are Eligible Persons, each must enroll as a Participant. Except as described in Section 4: When Coverage Begins, Eligible Persons may not enroll.	We determine who is eligible to enroll under the Plan.
	Plan for Retirees Eligible Person refers to two types of person who meets the eligibility rules: • Eligible Retiree. • Eligible Survivor. When an Eligible Person actually enrolls, we refer to that person as a Participant. For a complete definition of Eligible Person Eligible Retiree, Eligible Survivor, and Participant, see Section 10: Glossary of Defined Terms. If both spouses are Eligible Persons each must enroll as a Participant. Except as described in Section 4: When Coverage Begins, Eligible Persons may not enroll.	We determine who is eligible to enroll under the Plan.

Who	Description	Who Determines Eligibility
Dependent	***Plan for Employees*** Dependent refers to five types of person who meets the eligibility rules: • Participant's Spouse • Participant's Children. • Participant's Grandchild. • Domestic Partner. • Domestic Partner's Children if Domestic Partner is covered. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent, Participant's Spouse, Participant's Children, Domestic Partner, Domestic Partner's Children, and Enrolled Dependent, see Section 10: Glossary of Defined Terms. Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan. If both parents of a child are enrolled as a Participant, only one parent may enroll the child as a Dependent. Except as described in Section 4: When Coverage Begins, Dependents may not enroll unless eligible under a qualified change in status.	We determine who qualifies as a Dependent.
	Plan for Retirees Dependent refers to three types of person who meets the eligibility rules: • Participant's Spouse • Participant's Children. • Participant's Grandchild. Dependents must either be continuously enrolled from the date of retirement of the Eligible Retiree or Eligible Survivor or from October 1, 2005, whichever is later. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent, Participant's Spouse, Participant's Children, and Enrolled Dependent, see Section 10: Glossary of Defined Terms. Dependents of an Eligible Person	We determine who qualifies as a Dependent.

Who	Description	Who Determines Eligibility
	may not enroll unless the Eligible Person is also covered under the Plan. If both parents of a Dependent child are enrolled as a Participant, only one parent may enroll the child as a Dependent. Except as described in Section 4: When Coverage Begins, Dependents may not enroll unless eligible under a qualified change in status.	

When to Enroll and When Coverage Begins

When to Enroll	Who Can Enroll	Begin Date
Annual Enrollment Period		
Plan for Employees The Annual Enrollment Period is the 30 day period during which an Eligible Person may select the benefit coverages he or she will receive during the following Plan Year.	Eligible Persons may enroll themselves and their Dependents. Eligible Employees may enroll a Domestic Partner. Eligible Employees may only enroll one adult as a Dependent.	The Plan Sponsor determines the Annual Enrollment Period. Coverage begins on October 1st if the Eligible Person completes the enrollment process within 31 days of the date Annual Enrollment begins.
Plan for Retirees The Annual Enrollment Period is the 30 day period during which an Eligible Person may select the benefit coverages he or she will receive during the following Plan Year. The Eligible Person may select the Choice Plus Plan for Travis County Retirees, the Choice Plan for Travis County Retirees or the Coinsured Choice Plan for Travis County Retirees.	Eligible Persons may enroll themselves and, if their Dependents have been continuously enrolled from the date of retirement of the Eligible Retiree or Eligible Survivor or from October 1, 2005, they may enroll their Dependents.	The Plan Sponsor determines the Annual Enrollment Period. Coverage begins on October 1st if the Eligible Person completes the enrollment process within 31 days of the date Annual Enrollment begins.

When to Enroll	Who Can Enroll	Begin Date
Newly Eligible Persons		
Plan for Employees These are newly hired Eligible Employees.	Newly Eligible Persons may enroll themselves and their Dependents. Newly Eligible Employees may enroll a Domestic Partner. Eligible Employees may only enroll one adult as a Dependent.	Coverage for newly Eligible Employees begins on the first day of the month following the completion of a 30 day waiting period if the Eligible Person properly completes the enrollment process within 30 days of the date the newly Eligible Person becomes eligible to enroll.
Plan for Retirees These are newly retired Eligible Retirees and newly Eligible Survivor.	Newly Eligible Persons for the Choice Plan for Travis County Retirees may enroll themselves and their Dependents if they have been enrolled prior to retirement.	Coverage for newly retired Eligible Retirees and newly Eligible Survivors begins immediately.
Adding New Dependents		
Plan for Employees Other than Annual Enrollment Periods, new Dependents can only be added when the proposed person satisfies all criteria for that type of dependent.	Participants may enroll Dependents when they meet the criteria: • Domestic Partner. Eligible Employees may only enroll one adult as a Dependent.	Coverage begins on the first day of the first month after all criteria are met, if the Eligible Person requests and completes an enrollment process within 30 days of meeting all the criteria.
Plan for Retirees New Dependents cannot be enrolled after they are newly eligible.		

Special Enrollment Period

Plan for Employees

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

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

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

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal Guardianship.
- Court or Administrative Order.

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

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

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Birth or Adoption. Coverage begins on the date of the birth or adoption if the Eligible Person completes the enrollment process within 30 days of the birth or adoption.

Marriage. Coverage begins on the first day of the month after the marriage if the Eligible Person completes the enrollment process within 30 days of the event.

Loss of Other Coverage. Coverage begins on the first day of the month after the loss of coverage event date if the Eligible Person completes the enrollment process within 30 days of the event.

Legal Guardianship. Coverage begins on the first day of the month following a full 30 days if the Eligible Person completes the enrollment process within 30 days of the event.

Court or Administrative Order. Coverage begins on the date noted on the court order.

When to Enroll	Who Can Enroll	Begin Date
	— The employer stopped paying the contributions. — In the case of COBRA continuation coverage, the coverage is exhausted.	

Plan for Retirees

There is no special enrollment for retirees or their dependents.

Section 5: How to File a Claim

This section provides you with information about:

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

If You Receive Covered Health Services from a Network Provider

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

Filing a Claim for Non-Network Benefits

When you receive Covered Health Services from a Non-Network provider as a result of an Emergency or if the Claims Administrator refers you to a Non-Network provider, you must request payment from us through the Claims Administrator.

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

If you don't submit a request for payment of Benefits within 12 months after the date of service Benefits for that health service will be denied unless it was not reasonably possible to file the claim within 12 months and proof is given as soon as possible. (This time limit does not apply if you are legally incapacitated.) If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

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

A. Participant's name and address.
B. The patient's name, age and relationship to the Participant.
C. The member number stated on your ID card.
D. An itemized bill from your provider that includes the following:
   - Patient diagnosis
   - Date of service or supplies incurred
   - Procedure code(s) and description of service(s) rendered
   - Provider of service (Name, Address and Tax Identification Number)
E. The date the Injury or Sickness began.
F. A statement indicating whether you are 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).

Benefit Determinations

Through the Claims Administrator, we will make a benefit determination.

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Urgent Requests for Benefits that Require Immediate Action

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

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

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

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

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

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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 appeal procedures.

Post-Service Claims

Post-Service Claims are claims that are filed 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 you don't provide the needed information within 45 days, your claim will be denied.

If all of the needed information is received within the 45 days and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received.

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

Pre-Service Requests for Benefits

Pre-service requests for Benefits are requests that require notification or approval before receiving medical care. If your pre-service request for Benefits was submitted properly with all needed information, you will receive written notice of the decision from the Claims Administrator within 15 days of receipt of the request. If you did not file a pre-service request for Benefits properly, the Claims Administrator will notify you of how to correct it within 5 days after

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the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, the Claims Administrator will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15 days and pend your request until all information is received. You then have 45 days to provide this information. If you don't provide the needed information within 45 days, your claim will be denied. If all of the needed information is received within 45 days, the Claims Administrator will notify you of the determination within 15 days after the information is received. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for Benefits, your request will be decided within 24 hours, provided your request is made at least 24 hours before 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 before the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the urgent request timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

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Benefit Determinations

You may not assign your Benefits under the Plan to a Non-Network provider without our consent. The Claims Administrator may, however, in its discretion, pay a Non-Network provider directly for services rendered to you.

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Section 6: Questions, Complaints 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 have a complaint.
- How to handle an appeal that requires immediate action.
- You are notified that a claim has been denied because it has been determined that a service or supply is excluded under the Plan and you wish to appeal such determination.

What to Do First

If your 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 concern in writing. If you are not satisfied with a benefit determination as described in Section 5: How to File a Claim, you may appeal it without informally contacting Customer Service. 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, refer to the "Urgent Appeals that Require Immediate Action" section below and contact Customer Service immediately.

The Customer Service telephone number is shown on your ID card.

How to Appeal a Claim Decision

If you disagree with a pre-service request for Benefits determination or post-service claim determination after following the steps in Section 5, you can contact the Claims Administrator in writing to formally 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.

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

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

will be conducted and you will be notified by the Plan Sponsor as described in Appeal to Plan Sponsor.

Appeal Process to Claims Administrator

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

Appeals Determinations

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.

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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.

First Level Appeals

Pre-Service Requests for Benefits Appeals

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

For appeals of pre-service requests for Benefits as defined in Section 5: 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 request for Benefits.

Post-Service Requests for Benefits Appeals

For appeals of post-service claims as defined in Section 5: 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.

Second Level Appeals to Plan Sponsor

If you are dissatisfied with the Claims Administrator's decision, you may appeal that decision to the Plan Sponsor. You may not appeal that decision until all appeal procedures available through the Claims Administrator have been exhausted.

You must file your appeal to the Plan Sponsor with its Risk and Benefit Manager at its Human Resources Management Department within 30 days after you receive the first level appeal decision of coverage for Health Services from the Claims Administrator. The appeal must be in writing and must include at least the following information and authorizations:

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- Your name and social security number
- The name of the person whose care is being appealed
- The name and address of the medical providers involved
- A clear statement of the level of service requested and the amount of indemnity request
- A detailed explanation of the reason that the appeal should be considered
- Copies of all documents previously submitted for consideration to the Claims Administrator for its review of its decision not to approve coverage for Health Services
- An authorization for release of medical information to the Risk and Benefit Manager, the Appeals Committee panel hearing the appeal, and the County Attorney advising the panel, and
- An authorization for review and discussion of medical information to the Risk and Benefit Manager, the Appeals Committee panel hearing the appeal, and the County Attorney advising the panel as necessary to hear and determine the appeal.

The appeal should be enclosed in a sealed envelope or a sealed box and marked "Confidential Appeal" to notify the Plan Sponsor that the contents should be kept confidential. If the appeal is marked "Confidential Appeal", it will only be opened by the Risk and Benefit Manager or the Director of the Human Resources Management Department.

Within five businesses days after receipt of an appeal, the Risk and Benefit Manager will establish an Appeal Committee panel of three members from the Appeals Committee appointed by the Commissioners Court. This panel will include at least one licensed medical practitioner with expertise that is appropriate to the medical issue being appealed and the Risk and Benefit Manager or his representative. The Risk and Benefit Manager will set the time,

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location, and agenda for the Appeals Committee hearing and post Open Meetings notices.

The panel will review the information you submitted and hold a hearing to make a decision about the appeal. A representative of the County Attorney may also attend the appeal hearing but cannot vote on the appeal.

The Appeals Committee panel must issue a written decision with reasons for its decision within 7 business days after the Risk and Benefit Manager receives the complete written appeal. Written decisions of a panel of the Appeal Committee will not include any information that identifies who you are, like your name or social security number. This 7 business days does not begin until you have provided all of the required information.

Meetings of an Appeals Committee panel must comply with the Texas Open Meetings Act. Notice of meetings must be posted and the panel may go into closed session to discuss the appeal.

You may present information to the Appeals Committee panel at the hearing in both open and closed session. If you present the information in writing, you can preserve the confidentiality of your identity. If you choose to present information orally in person in open session at the hearing of the panel, the fact that you presented the information in this manner acts as a release of the medical information presented to everyone at the open session of the hearing and a waiver of any right you would otherwise have to confidentiality of your identity.

You will be allowed to be present in the closed session unless the panel needs to receive legal advice about the appeal. You will not be allowed to be present for any legal advice that is provided in closed session.

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All written information you provide in the appeal, all oral information you provide in closed session at the hearings, and all discussions about any appeal by the Appeal Committee panel must be kept confidential.

The Plan Sponsor must notify you of the second level appeal decision within 30 days after receiving the second level appeal from you.

The Plan Sponsor has the exclusive right to interpret and administer the Plan. The decision of the Appeals Committee panel is final. There is no further appeal of this decision.

The Plan Sponsor'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.

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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. 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 determine which Coverage Plan will pay as the Primary Coverage Plan. The Primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some expenses. A Secondary Coverage Plan pays after the Primary Coverage Plan and may reduce the benefits it pays. This is to prevent payments from all group Coverage Plans from exceeding 100 percent of the total Allowable Expense.

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NOTE: This Coordination of Benefits provision does not apply to Prescription Drug Products covered through this Plan.

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, or no-fault, benefits under group or individual automobile contracts; medical benefits coverage under homeowner's insurance; 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.

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

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

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

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

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

4. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.
5. "Closed Panel Plan" is a Coverage Plan that provides health benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
6. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with

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

Order of Benefit Determination Rules

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

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

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

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

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

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

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

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

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

1) The parents are married;

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

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

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

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

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

1) The Coverage Plan of the custodial parent;

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 the Coverage Plans meeting the definition of Coverage Plan

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

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

Effect on the Benefits of this Plan

A. When this Coverage Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Coverage Plans during a claim determination period are not more than 100 percent of total Allowable Expenses. As each claim is submitted, this Coverage Plan will determine its obligation to pay or provide benefits under its contract.

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

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

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

1. 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.

2. 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

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are determined as if the services were covered under Medicare Parts A and B.

3. 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.

4. 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.

5. The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

Right to Receive and Release Needed Information

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

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

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we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied but will be reprocessed when the needed information is provided.

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 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).

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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 after 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
Entire Plan Ends	Your coverage ends on the date the Plan ends. We are responsible for notifying you that your coverage has ended.
You Are No Longer Eligible	Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Participant or Enrolled Dependent. See Section 10: Glossary of Defined Terms for a more complete definition of the terms "Eligible Person", "Eligible Employee", "Eligible Retiree", "Eligible Survivor", "Participant", "Dependent" and "Enrolled Dependent".
Claims Administrator Receives Notice to End Coverage	Your coverage ends on the last day of the calendar month in which the Claims Administrator receives written notice from us instructing the Claims Administrator to end your coverage, or the date requested in the notice, if later.
Participant Retires	Your coverage as an Eligible Employee ends the last day of the calendar month in which the Participant is retired if you do not enroll as an Eligible Retiree under the Plan. We are responsible for providing written notice to the Claims Administrator to end your coverage. This provision applies for retired persons, only if the Participant continues to meet any applicable eligibility requirements and makes the required premium payments.

Other Events Ending Your Coverage

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

Ending Event	What Happens
Fraud, Misrepresentation or False Information	Fraud or misrepresentation, or because the Participant knowingly gave us or the Claims Administrator false material information. Examples include false information relating to another person's eligibility or status as a Dependent. We have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.
Material Violation	There was a material violation of the terms of the Plan.
Improper Use of ID Card	You permitted an unauthorized person to use your ID card, or you used another person's card.
Failure to Pay	You failed to pay a required contribution.
Threatening Behavior	You committed acts of physical or verbal abuse that pose a threat to our staff, the Claims Administrator's staff, a provider, or other Covered Persons.

Coverage for a Handicapped Child

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:

- Enrolled Dependent child is not able to be self-supporting because of mental retardation or physical handicap.
- Enrolled Dependent child 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 Claims 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 Claims Administrator agrees to this extension of coverage for the child, the Claims Administrator may require that a Physician chosen by us examine the child. We will pay for that examination.

The Claims Administrator may continue to ask you for proof that the child continues to meet these conditions of incapacity and dependency. This 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 Claims Administrator's request as described above, coverage for that child will end.

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

Continuation Coverage under Federal Consolidated Omnibus Budget Reconciliation Act ("COBRA")

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 Spouse who is an Enrolled Dependent.
- A Participant's Child who is an Enrolled Dependent, including a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law.
- A Participant's former legal spouse, at the time of separation or divorce.

A Domestic Partner and a Domestic Partner's Child are not Qualified Beneficiaries.

Qualifying Events for Continuation Coverage under 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.

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

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

With respect to a Participant's Spouse or Participant's Child who is a Qualified Beneficiary, the qualifying events are:

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

Notification Requirements and Election Period for Continuation Coverage under COBRA

Notification Requirements for Qualifying Event

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

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

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

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

Notification Requirements for Disability Determination or Change in Disability Status

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

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

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

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

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

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

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Participant will lose these special COBRA rights. COBRA

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coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period

Terminating Events for Continuation Coverage under 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 events A and B).

   If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at any time within the first 60 days of continuation coverage for qualifying event A or B, then the Qualified Beneficiary may elect an additional eleven months of continuation coverage (for a total of twenty-nine months of continued coverage) subject to the following conditions:

   6. Notice of such disability must be provided within the latest of 60 days after:
      a. the determination of the disability; or
      b. the date of the qualifying event; or
      c. the date the Qualified Beneficiary would lose coverage under the Plan; and
      d. in no event later than the end of the first eighteen months.
   7. The Qualified Beneficiary must agree to pay any increase in the required premium for the additional eleven months.

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8. If the Qualified Beneficiary who is entitled to the eleven months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional eleven months of continuation coverage.

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

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

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

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

2. Thirty-six months from the date of the Participant's Medicare entitlement, if a second qualifying event (that was due to either the Participant's termination of employment or the Participant's work hours being reduced) occurs prior to the expiration of the eighteen months.

D. For Qualified Beneficiaries, and to the extent that the Participant became entitled to Medicare subsequent to the qualifying event:

1. Thirty-six months from the date of the Participant's termination from employment or work hours being reduced (first qualifying event) if:

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

a. The Participant's Medicare entitlement occurs within the eighteen month continuation period; and
b. Absent the first qualifying event, the Medicare entitlement would have resulted in a loss of coverage for the Qualified Beneficiary under the group health plan.

E. The date coverage terminates under the Plan for failure to make timely payment of the premium.

F. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

G. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event G). If the Qualified Beneficiary was entitled to continuation because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event G) and the retired Participant dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for thirty-six months from the date of the Participant's death.

H. The date the entire Plan ends.

I. The date coverage would otherwise terminate under the Plan as described in this section under the heading Events Ending Your Coverage.

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

Section 9: General Legal Provisions

This section provides you with information about:
- General legal provisions concerning the Plan.

Plan Document

This SPD is part of the official plan documentation and represents an overview of your medical and pharmacy Benefits. The Claims Administrator administers for medical and pharmacy benefits in accordance with the SPD. The official plan documentation includes information not found in the medical SPD such as other employee benefits that may be available to you (e.g., dental, FSA, life, disability etc.) and associated benefit communications including insurance policies, certificates, booklets, benefit brochures, employee web site information, and enrollment guides. In the event there is a discrepancy between the SPD and the official plan documentation, the plan documentation governs. A copy of the plan documentation is available upon written request from the Plan Administrator. You (or your personal representative) may obtain a copy of this documentation, for a nominal charge, by written request to the Plan Administrator.

Our 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.

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

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. We do not have any other relationship with Network providers such as principal-agent or joint venture. Neither we nor the Claims Administrator are liable for any act or omission of any provider.

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

We are solely responsible for all of the following:

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

Your Relationship with Providers

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

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

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

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

Incentives to Providers

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

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

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

Rebates and Other Payments

We and the Claims Administrator may receive rebates for specified drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. We and the Claims Administrator do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copayments and CoInsurance.

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

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Administrative Services

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

Amendments to the Plan

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 federal statutes or regulations, or applicable state law provisions not otherwise preempted by the Public Health Service Act 42 U.S.C. 300bb-3 (of the jurisdiction in which the Plan is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

Any change or amendment to or termination of the Plan, its benefits or its terms and conditions, in whole or in part, shall be made solely in a written amendment to the Plan (in the case of a change or amendment) or in a written resolution (in the case of a termination), whether prospective or retroactive, 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.

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

Clerical Error

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

Information and Records

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

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

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

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the information gathered under the Plan for research and analytic purposes.

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

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

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

Examination of Covered Persons

If a question or dispute about your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

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

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.

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

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you **should** enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, we will assume the position of a secondary payer as described in Section 7: Coordination of Benefits, and 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 and Reimbursement

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

Right to Subrogation

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

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

Right to Reimbursement

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

Third Parties

The following persons and entities are considered third parties:

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

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

Subrogation and Reimbursement Provisions

As a Covered Person, you agree to the following:

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- The Plan may enforce its subrogation and reimbursement rights regardless of whether you have been "made whole" (fully compensated for your injuries and damages).
- You will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - Complying with the terms of this section.
  - Providing any relevant information requested.
  - Signing and/or delivering documents at its request.
  - Appearing at medical examinations and legal proceedings, such as depositions or hearings.
  - 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

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alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.

- If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- You will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a Sickness or Injury caused by a third party.
- The Plan's rights will not be reduced due to your own negligence.
- The Plan may file suit in your name and take appropriate action to assert its rights under this section. The Plan is not required to pay you part of any recovery it may obtain from a third party, even if it files suit in your name.
- The provisions of this section apply to the parents, guardian, or other representative of an Enrolled Dependent child who incurs a Sickness or Injury caused by a third party.
- In case of your wrongful death, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs.
- 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.

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Refund of Overpayments

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

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

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

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

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 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 and that provides one or more of the following services on an outpatient basis, as permitted by law:

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

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

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

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.

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Cancer Resource Services Program - the program made available by the Plan Sponsor to Participants. The Cancer Resource Services Program provides information to Participants or their Enrolled Dependents with cancer and offers access to additional cancer centers for the treatment of cancer.

Child - an unmarried dependent child of the Participant or Participant's spouse, under 26 years of age who is primarily dependent upon the Eligible Employee for support and maintenance and who is not regularly employed on a full time basis for 20 hours or more per week. The term child includes any of the following:

- A natural child.
- A stepchild
- A grandchild who resides in the Participant's home and for whom a validly executed and notarized guardianship document has been submitted to Human Resources Management Division.
- A legally adopted child.
- A child placed for adoption.

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

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

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Claims Administrator - the company (including its affiliates) that provides specified 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 after birth.

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

A Covered Health Service is a health care service or supply or equipment 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 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 and the services do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

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Dependent - the Participant's Spouse or a Participant's Child or Participant's Domestic Partner or Domestic Partner's Child if the Domestic Partner is covered.

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

Dependents must live in the United States.

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.

Domestic Partner - a person who meets all of the following conditions:

- Not employed by the Eligible Employee.
- Not be related to the Eligible Employee by marriage.
- Not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- Share the same residence and the common necessities of life with the Eligible Employee for at least six months before applying for coverage and currently living with the Eligible Employee.
- Have a relationship with the Eligible Employee that includes shared expenses and shared responsibilities for the maintenance and operation of their shared residence

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- Have provided Plan Sponsor with an Affidavit of Domestic Partnership that includes the names of any child for whom coverage is sought.
- Not in active service in the armed forces.
- At least 18 years of age.

A Domestic Partner is not dependent for the purpose of determining a qualified beneficiary as defined in COBRA. Domestic Partners are not eligible for COBRA continuation.

Domestic Partner's Child - a Child of Eligible Employee's Domestic Partner who has been living with the Eligible Employee for at least six months before applying for coverage and is currently living with the Eligible Employee if the Domestic Partner is covered. The term Domestic Partner's Child also includes a child for whom legal guardianship has been awarded to the Participant's Domestic Partner.

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

A Domestic Partner's Child is not dependent for the purpose of determining a qualified beneficiary as defined in COBRA. A Domestic Partner's Child is not eligible for COBRA continuation.

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

Eligible Expenses are based on either of the following:

- When Covered Health Services are received from Network providers, Eligible Expenses are the contracted fee(s) with that provider.

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- When Covered Health Services are received from Non-Network providers as a result of an Emergency or as otherwise arranged through the Claims Administrator, Eligible Expenses are billed charges unless a lower amount is negotiated.

Eligible Person –

Plan for Travis County Employees - an Eligible Employee.

Eligible Persons must live in the United States.

Plan for Travis County Retirees - an Eligible Retiree, or an Eligible Survivor.

Eligible Persons must live in the United States.

Eligible Employee - a current regular full-time employee of the Plan Sponsor who is scheduled to work at his or her job at least 20 hours per week.

Eligible Retiree - a person who meets all of the following conditions:

- terminated or retired from Plan Sponsor
- receiving annuity benefits from the Texas District and County Retirement Association due to employment with Plan Sponsor
- either:
  - continuously covered by a Plan for Retirees or a former Plan for Retirees since termination or retirement, or
  - covered as a retiree on October 1, 2005 and continuously covered by a Plan for Retirees or a former Plan for Retirees since then.

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Eligible Survivor - either of the following:

- A surviving spouse of any person who was receiving annuity benefits from the Texas District and County Retirement Association due to employment with Plan Sponsor if the surviving spouse was covered by the Plan or the former Plan of the Plan Sponsor at the time of the retired person's death and has maintained continuous coverage since the date of the retired person's death, or
- A person who qualifies as an eligible survivor under Subchapter D, Chapter 615 of TEX. GOV'T CODE ANN.

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

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

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

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

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- 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.
- Is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations.
- Is approved by Medicare as a Hospital.
- Is operated continuously with organized facilities for operative surgery on the premises.

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.

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

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

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

Medicare - Parts A, B, C and D 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.

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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 Mental Disorders* published by the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

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

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of Mental Disorders* published by 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 (either directly or indirectly) with the Claims Administrator or with the Claims Administrator's affiliate to participate in the Claims Administrator's Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with them through common ownership or control with the Claims Administrator or with its ultimate corporate parent, including direct and indirect subsidiaries.

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

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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.

Participant's Child - a Child of the Participant or the Participant's Spouse. The term Participant's Child also includes a child for whom legal guardianship has been awarded to the Participant or the Participant's Spouse.

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

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

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

Plan - Choice for Travis County Employee Health Benefit Fund Plan.

Plan Administrator - is Travis County or its designee.

Plan Sponsor - Travis County. References to "we", "us", and "our" throughout the SPD refer to the Plan Sponsor.

Pregnancy - includes all of the following:

- Prenatal care.

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

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

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

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

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

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

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)

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- 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.)

Working Day - any business day for County and does not include Saturday, Sunday or County holidays.

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Riders, Amendments, Notices

Outpatient Prescription Drug Rider

Attachment I

Attachment II

Choice

Outpatient Prescription Drug Rider

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Outpatient Prescription Drug Rider

This Rider to the SPD provides Benefits for outpatient Prescription Drug Products. Benefits are provided for outpatient Prescription Drug Products at a Network Pharmacy. Certain capitalized words have special meanings. We have defined these words in Section 10: Glossary of Defined Terms of the SPD and in Section 3: Glossary of Defined Terms of this Rider.

"We," "us," and "our" in this document refer to Plan Sponsor. "You" and "your" refer to people who are Covered Persons as the term is defined in the SPD Section 10: Glossary of Defined Terms.

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

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Introduction

Benefits for Outpatient Prescription Drug Products

Benefits are available for Outpatient Prescription Drug Products at a Network Pharmacy and are subject to Copayments. There is no coverage for Prescription Drugs dispensed at a Non-Network Pharmacy.

Identification Card (ID Card) - Network Pharmacy

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

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment and any deductible that applies.

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Designated Pharmacies

If you require certain Prescription Drug Products, the Claims Administrator may direct you to a Designated Pharmacy with whom we have an exclusive arrangement to provide those Prescription Drug Products.

In this case, Benefits will only be paid if your Prescription Order or Refill is obtained from the Designated Pharmacy.

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Rebates and Other Payments

We and the Claims Administrator may receive rebates for certain drugs included on the Prescription Drug List. We or the Claims Administrator do not pass these rebates on to you, nor are they taken into account in determining your Copayments.

The Claims Administrator, and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this Outpatient Prescription Drug Rider. Such business may include data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Outpatient Prescription Drug Rider. The Claims Administrator is

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not required to pass on to you, and does not pass on to you, such amounts.

Coupons, Incentives and Other Communications

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

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

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

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

Benefits for Outpatient Prescription Drug Products

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

When a Brand-name Drug Becomes Available as a Generic

When a Generic becomes available for a Brand-name Prescription Drug Product, your Copayment may change. You will pay the Copayment applicable for a Brand-name Prescription Drug with a Generic Prescription Drug available.

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Supply Limits

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

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

Notification Requirements

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

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

Network Pharmacy Notification

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

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

If the Claims Administrator is not notified before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy.

Pharmacy Benefit Claims

If you are asked to pay the full cost of a prescription when you fill it at a Network Retail or mail-order pharmacy and you believe that the Plan should have paid for it, you may submit a claim for reimbursement as a post-service group health plan claim. If you pay a Copayment and you believe that the amount of the Copayment was incorrect, you also may submit a claim for reimbursement as a post-service group health plan claim.

If a Network Retail or mail order pharmacy fails to fill a prescription that you have presented, you may contact the Claims Administrator by submitting a claim for coverage as a pre-service health plan claim.

You may seek information regarding claims in Section 5: How to File a Claim, and information on appeals in the SPD Section 6 Questions, Complaints and Appeals.

When you submit a claim on this basis, you may pay more because you did not notify the Claims Administrator before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost (for Prescription Drug Products from a Network Pharmacy), less the required Copayment and any deductible that applies.

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

Specialty Prescription Drugs

If you require certain Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an exclusive arrangement to provide those Prescription Drug Products. In this case, benefits will only be paid if your prescription order or refill is obtained from the Designated Pharmacy.

What You Must Pay

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

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

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

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Payment Information

Payment Term	Description	Amounts
Copayment	Copayments for a Prescription Drug Product at a Network Pharmacy are a specific dollar amount. Your Copayment is determined by the type of Prescription Drug Product. Copayments for compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are determined by the category that applies to the main active ingredient in the drug.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment or • The Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug Product. For Prescription Drug Products from a home delivery Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment or • The Prescription Drug Cost for that Prescription Drug Product. ***See the Copayments stated in the Benefit Information table for amounts.*** Drugs which are prescribed, dispensed, or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility are not subject to a Copayment.

Description of Pharmacy Type and Supply Limits	Your Copayment Amount
Prescription Drugs from a Retail Network Pharmacy Benefits are provided for outpatient Prescription Drug Products dispensed by a retail Network Pharmacy. The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Copayment for each cycle supplied. If your physician orders or approves filling your Prescription Drug Order so that you must split the tablets provided to get the appropriate dosage, your Copayment is **half** of the Copayment for the type of Prescription Drug Product prescribed that is shown in the adjacent column.	\$10.00 per Prescription Order or Refill for a **Generic Prescription Drug Product**. \$25.00 per Prescription Order or Refill for a **Brand-Name Prescription Drug Product** when a generic equivalent is not available. \$45.00 per Prescription Order or Refill for a **Brand-Name Prescription Drug Product** when a generic equivalent is available and when provided to a Covered Person who is not a retiree or retiree's dependent **and Specialty Prescription Drug Products** when purchased from a Designated Pharmacy regardless of retiree status. \$35.00 per Prescription Order or Refill for a **Brand-Name Prescription Drug Product** when a generic equivalent is available and when provided to an Eligible Retiree Participant or that retiree's dependent.

Prescription Drug Products from a Home Delivery Network Pharmacy

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

- As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a home delivery Copayment for any Prescription Orders or Refills sent to the home delivery pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or refill for a 90-day supply, not a 30-day supply with three refills.

If your Prescription Drug Order is written so that you must split the tablets provided to get the appropriate dosage, your Copayment is **half** of the Copayment for the type of Prescription Drug Product prescribed that is shown in the adjacent column.

For up to a 90-day supply, your Copayment is:

$20.00 per Prescription Order or Refill for a **Generic Prescription Drug Product**.

$50.00 per Prescription Order or Refill for a **Brand-Name Prescription Drug Product** when no generic equivalent is available.

$90.00 per Prescription Order or Refill for a **Brand-Name Prescription Drug Product** when a generic equivalent is available and when provided to a Covered Person who is not a retiree or retiree's dependent **and Specialty Prescription Drug Products** when purchased from a Designated Pharmacy regardless of retiree status.

$70.00 per Prescription Order or Refill for a **Brand-Name Prescription Drug Product** when a generic equivalent is available and when provided to an Eligible Retiree Participant or that retiree's dependent.

Section 2: What's Not Covered--Exclusions

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

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

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17. Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill.
18. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug. Prescription Drug Products that are comprised of components that are available in over-the-counter form or equivalent.
19. New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by the Claims Administrator's Prescription Drug List Management Committee.
20. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

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Section 3: Glossary of Defined Terms

This section:

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

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

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

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

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

Network Pharmacy - a pharmacy that has:

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

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

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

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

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

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

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - Standard insulin syringes with needles;
  - Blood-testing strips - glucose;
  - Urine-testing strips - glucose;
  - Ketone-testing strips and tablets;
  - Lancets and lancet devices;
  - Glucose monitors.

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

Specialty Prescription Drug Product - Prescription Drug Products that are identified by Plan Administrator as a Specialty Drug, which are generally high cost, biotechnology or genetically-engineered drugs used to treat patients with certain illnesses.

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

- End of Outpatient Prescription Drug Rider -

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Attachment I

Women's Health and Cancer Rights Act of 1998

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

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

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

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

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

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

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Attachment II

Travis County Employee Health Benefit Fund Plan Document

The Use and Disclosure of Protected Health Information and Security of Electronic Protected Health Information

Under the federal privacy regulations enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your health plans are required to protect the confidentiality of your Protected Health Information. Protected Health Information (PHI) is individually identifiable health information related to your condition, services provided to you, or payments made for your care, which is created or received by a health plan, a health care clearinghouse, or a health care provider that electronically transmits such information. Travis County Employee Health Benefit Fund and Travis County, Texas will not use or disclose health information protected by HIPAA, except for treatment, payment, health plan operations (collectively known as "TPO"), as permitted or required by other state and federal law, or to business associates to help administer the Plan.

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All disclosures of the PHI by a health insurance issuer or HMO to the Plan Sponsor will comply with the restrictions and requirements set forth in the Plan and in the "504" provisions.

The Plan may not, and may not permit a health insurance issuer or HMO, to disclose members' PHI to the Plan Sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of

- Obtaining premium bids from health plans for providing health insurance coverage under the Plan, or
- Modifying, amending, or terminating the Plan.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the "504" provisions.

Further, Travis County, Texas will take reasonable steps to ensure that any use or disclosure is the minimum necessary to accomplish the task.

In addition, under the federal security regulations enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your health plans are required to safeguard the confidentiality and ensure the integrity and availability of your Electronic Protected Health Information. Electronic Protected Health Information (ePHI) is PHI that is maintained or transmitted in electronic form. Travis County Employee Health Benefit Fund and Travis County, Texas will reasonably and appropriately

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safeguard ePHI created, received, maintained, or transmitted to or by Travis County, Texas on behalf of the Plan.

The Plan and Travis County, Texas exchange information to coordinate your Plan coverage. Travis County, Texas agrees to and has certified that it will:

- Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;
- Ensure that any agents, including subcontractors, to whom it provides PHI received from Travis County Employee Health Benefit Fund agree to the same restrictions and conditions that apply to Travis County, Texas with respect to such information;
- Not use or disclose PHI for employment-related actions and decisions;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of Travis County, Texas;
- Notify the Risk and Benefit Manager of any improper use or disclosure of PHI of which it becomes aware;
- Make PHI available to an individual based on HIPAA's access requirements;
- Make PHI available for amendment and incorporate any changes to PHI based on HIPAA's amendment requirements;
- Make available the information required to provide an accounting of disclosures of PHI;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with HIPAA;
- Ensure adequate separation of management between the Plan and Plan Sponsor as required by HIPAA; and

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- If feasible, return or destroy all PHI that Travis County, Texas still maintains in any form and retain no copies of such PHI when no longer needed for the specified disclosure purpose. If return or destruction is not feasible, Travis County, Texas will limit further uses and disclosures to those purposes that make the return or destruction infeasible.

In order to receive ePHI from the Plan, Travis County, Texas agrees that it will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that Travis County, Texas creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that access to, and use and disclosure of ePHI by the employees or classes of employees described in this Plan document is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom Travis County, Texas provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the Risk and Benefit Manager any security incident of which Travis County, Texas becomes aware.

Only the following classes of employees under the control of Travis County, Texas may have access to PHI or ePHI:

- HR/Benefit Analyst. This class also includes those persons responsible for interacting with members, employees, providers, business associates, and others in resolving eligibility, benefits, claims, coordination of benefits, and other plan administration issues.

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- Information Technology Administrators, Operations Support Personnel and Technical Support Personnel. These personnel include personnel responsible for creating and maintaining plan content, information, data sets and applications, and other related information Assets. These personnel may also be responsible for organization web sites, connectivity within the organization's networks, electronic mail, and connectivity with external networks.

- Clerical Personnel. These personnel include mail personnel, secretarial support, and others responsible for document handling and preparation.

- Supervision. Supervisors include only those persons who directly supervise other direct users of PHI.

- Financial Analysts for Health Plan.

- Benefit Administrator. This class also includes those responsible for preparing and submitting information to potential business associates and in managing performance of existing associates.

These employees may only have access to and use and disclose PHI for purposes of the plan administration.

If you believe your rights under HIPAA have been violated, you have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services. Travis County, Texas has provided a mechanism for resolving issues of noncompliance by employees described above who have access to PHI or ePHI. For more information about resolving issues of non-compliance, contract the Risk and Benefit Manager at the Human Resources Management Department, 2nd Floor, 1010 Lavaca street, Austin, Texas, (512) 854-9499. All other terms, provisions, and

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conditions shown in your Health Benefits Plan Booklet will continue to apply. All other terms, provisions and conditions shown in this SPD will continue to apply.

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Combined

Summary Plan Description (SPD)

Choice Plus Plan for Travis County Employees and Choice Plus Plan for Travis County Retirees

Group Number: 701254
Effective Date: October 1, 2009

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Introduction

This Summary Plan Description ("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 Amendments.

We especially encourage you to review the following:

- Benefit limitations in Section 1: What's Covered--Benefits and Section 2: What's Not Covered—Exclusions;
- Section 9: General Legal Provisions.

Many of the sections of the SPD are related to other sections. You may not have all of the information you need by reading just one section. You should call the Claims Administrator if you have questions about the limits of the coverage available to you.

Your Physician does not have a copy of your SPD and is not responsible for knowing or communicating your Benefits.

Note: This SPD is a combined description for multiple plans. The SPD describes the benefits offered in the following plans: Choice Plus Plan for Travis County Employees and Choice Plus Plan for Travis County Retirees.

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Information about Defined Terms

Certain capitalized words have the special meanings stated in Section 10: Glossary of Defined Terms. Refer to Section 10 for a clearer understanding of your SPD.

"We", "us", and "our" in this document refer to the Plan Sponsor.

"You" and "your" refer to people who are Covered Persons as 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 your contribution.

Customer Service and Claims Submittal

Customer Service Representative (for questions about Coverage or procedures): is shown on your ID card.

Claims Administrator for Prior Notification: is shown on your ID card.

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

Claims Submittal Address:
United HealthCare Insurance Company
Attn: Claims
P.O. Box 30555
Salt Lake City, Utah 84130-0555

Requests for Review of Denied Claims and Notice of Complaints:
United HealthCare Insurance Company
P.O. Box 30432
Salt Lake City, Utah 84130-0432

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Section 1: What's Covered--Benefits

This section provides you with information about:

- Accessing Benefits.
- Copayments, CoInsurance, Eligible Expenses.
- Annual Deductible, Out-of-Pocket Maximum, Maximum Plan Benefit.
- Covered Health Services.
- Covered Health Services that require you or your provider to notify the Claims Administrator before you receive them.

Accessing Benefits

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

You must show your identification card ("ID card") every time you request health care services from a Network provider. If you do not show your ID card, Network providers may bill you for the entire cost of the services you receive. For details about when Network Benefits apply, see Section 3: Description of Network and Non-Network Benefits.

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

- Covered Health Services are received after the Plan is in effect.
- Covered Health Services are received before 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 in the Plan.

Copayment and CoInsurance

Copayment and CoInsurance are the amounts you pay each time you receive certain Covered Health Services.

CoInsurance – the charge you are required to pay for specified Covered Health Services. CoInsurance is calculated as a percentage of Eligible Expenses.

Copayment – the charge you are required to pay for specified Covered Health Services. A Copayment is a set dollar amount.

Copayment and CoInsurance amounts are listed on the following pages next to the description for each Covered Health Service.

Eligible Expenses

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

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

When you receive Covered Health Services from Network providers, you are not responsible for any difference between the

Eligible Expenses and the amount the provider bills. When you receive Covered Health Services from Non-Network providers, you are responsible for paying, directly to the Non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses.

Out-of-Pocket Maximum

Out-of-Pocket Maximum – is the maximum amount you pay for Annual Deductible and CoInsurance every calendar year. Benefits with Copayments will never be payable at 100%. Where applicable, you will always pay a Copayment even after you have met your Out-of-Pocket Maximum.

If you use both Network Benefits and Non-Network Benefits, two separate Out-of-Pocket Maximums apply.

Once you reach the Out-of-Pocket Maximum for Network Benefits, we will pay Network Benefits for Covered Health Services at 100% CoInsurance for Eligible Expenses during the rest of that calendar year. Once you reach Out-of-Pocket Maximum for Non-Network Benefits, we will pay Non-Network Benefits for those Covered Health Services at 100% of Eligible Expenses during the rest of that calendar year.

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

- Any charges for non-Covered Health Services;
- Copayments for Covered Health Services available under this SPD or any Rider.
- The amount of any Benefits that is reduced if you don't notify the Claims Administrator as described in Section 1: What's Covered--Benefits.
- Charges that exceed Eligible Expenses.

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

- Any charges for non-Covered Health Services.
- Charges that exceed Eligible Expenses.
- The amount of any Benefits that is reduced if you don't notify the Claims Administrator as described in Section 1: What's Covered--Benefits.
- Copayments for Covered Health Services available under this SPD or any Rider.

Copayments for Covered Health Services in Section 1: What's Covered--Benefits do not apply to the Out-of-Pocket Maximum.

Requirement to Notify the Claims Administrator

In general, Network providers are responsible for notifying the Claims Administrator before they provide specified services to you. There are some Network Benefits, however, for which you must notify the Claims Administrator before you receive certain Covered Health Services.

For emergency services, notify the Claims Administrator as soon as possible, but at least one business day before post-Emergency treatment begins.

For Mental Health and Substance Abuse Benefits, you must get authorization in advance of any inpatient treatment through the Mental Health/Substance Abuse Designee by calling the telephone number on the back of your ID card. If you don’t notify the Mental

Health/Substance Abuse Designee, we will not pay any Benefits and you will be responsible for paying all charges.

When you receive specified Covered Health Services from Non-Network providers, you must also notify the Claims Administrator before you receive some specified Covered Health Services.

To ensure prompt and accurate payment of your claim as a Network Benefit, notify the Claims Administrator within two business days or as soon as possible after you receive outpatient Emergency Health Services at a Non-Network Hospital or Alternate Facility.

Services for which you must provide prior notification and the minimum notice period appear in the table labeled Benefit Information. See the heading **Notification Required**.

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

When you choose to receive services from Non-Network providers, confirm with the Claims Administrator that the services you plan to receive are Covered Health Services, even if not indicated in the table labeled Benefit Information. See the heading **Notification Required**, because the circumstances surrounding some procedures may affect whether the procedure is a Covered Health Service and whether it will be excluded. By calling before you receive treatment, you can determine if the service is subject to limitations or exclusions such as:

- The Cosmetic Procedures exclusion. Examples of procedures that may or may not be considered Cosmetic include: breast reduction and reconstruction (except 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.

If you don't notify the Claims Administrator, Benefits will be reduced by $250 for each hospital inpatient stay, each nursing facility stay, each reconstructive procedure, each treatment plan or single item of Durable Medical Equipment or prosthetic device; however, the reduction in Benefits will not exceed Eligible Expenses for the Covered Health Services. This reduction does not help you to meet the Annual Deductible or the Out of Pocket Maximum.

Benefits will not be reduced for the outpatient Emergency Health Services.

If you do not notify the Claims Administrator about Transplant Procedures, you will be responsible for paying all charges and Network Benefits will not be paid. Non-Network Benefits may be available.

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.

Special Note About Experimental, Investigational or Unproven Service

If you have a Sickness or condition that is likely to cause death within one year of your request for treatment, we and the Claims Administrator may, in our discretion, determine that an Experimental, Investigational or Unproven Service meets the definition of a Covered Health Service for that Sickness or condition if we and the Claims Administrator 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.

Special Note About Medicare

If you are eligible for Medicare please refer to Medicare Eligibility information in Section 9: General Legal Provisions.

Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services in a calendar year before we begin paying Benefits for Covered Health Services to which CoInsurance applies in that calendar year. The actual amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. See Eligible Expenses, in Section 10: Glossary of Defined Terms.	***Network*** $200 per Covered Person per calendar year, for not more than three Covered Persons in a family. ***Non-Network*** $750 per Covered Person per calendar year.
Out-of-Pocket Maximum	The maximum you pay, out of your pocket, in a calendar year for Annual Deductible and CoInsurance. For a complete discussion of Out-of-Pocket Maximum, see page 3 in this Section 1. The Out-of-Pocket Maximum does include the Annual Deductible.	***Network*** $1,500 per Covered Person per calendar year, for not more than two Covered Persons in a family. ***Non-Network*** $2,500 per Covered Person per calendar year, for not more than three Covered Persons in a family.
Maximum Plan Benefit	The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Plan or any other Plan of Plan Sponsor.	***Network and Non-Network Combined*** $2,000,000 per Covered Person.

Benefit Information

Description of Covered Health Service	Must You Notify the Claims Administrator?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
1. Acupuncture Services must be provided by a person who specializes in acupuncture and is licensed by the appropriate authority for regulating acupuncture within the jurisdiction in which the services are provided and is operating within the scope of that license. Services must be for one of the following conditions: • Post operative nausea • Nausea due to chemotherapy • Nausea during the first trimester of pregnancy • Treatment of pain Each treatment is limited to three modalities during a visit. Covered Services are limited to a combined total of 30 visits from both Network and Non-Network providers each Calendar Year.	***Network and Non-Network*** No	***Network*** **For a Primary Care Provider** $20 per visit **For a Non-Primary Care Provider** $35 per visit ***Non-Network*** 30%	No Yes	No Yes
2. Ambulance Services - Emergency and Medically Appropriate Only Emergency ambulance services by a licensed ambulance service whether transported or not. Transport is to the nearest Hospital that is medically equipped to perform the needed emergency health services. Ambulance services when required due to a medical condition.	***Network and Non-Network*** Yes, for medically appropriate transports. No, for Emergency transports.	***Network and Non-Network*** 10%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
3. Cancer Resource Services We will arrange for access to certain of our Network providers that participate in the Cancer Resource Services Program for the provision of oncology services. We may refer you to Cancer Resource Services, or you may self refer to Cancer Resource Services by calling 866-936-6002. The oncology services include Covered Health Services and supplies rendered for the treatment of a condition that has a primary or suspected diagnosis relating to cancer. In order to receive Benefits under this program, Cancer Resource Services must provide the proper notification to the Network provider performing the services. This is true even if you self refer to a Network provider participating in the program. When these services are not performed in a Cancer Resource Services facility, Benefits will be paid the same as Benefits for Hospital-Inpatient Stay, Outpatient Surgery, Diagnostic and Therapeutic Services, Physician's Office Services, and Professional Fees for Surgical and Medical Services stated in this Section 1: What's Covered—Benefits.	***Network*** Cancer Resource Services must be called.	***Network*** 10%	Yes	Yes
	Non-Network Non-Network Benefits for the Cancer Resource Services Program are not available.			

Description of Covered Health Service	Must You Notify the Claims Administrator?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
4. Colonoscopies and other Scopies Diagnostic and therapeutic scopic procedures and related services including laboratory charges received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office. Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy. Surgical scopic procedures, which are for the purpose of performing surgery. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.	***Network and Non-Network*** No	***Network*** 0%	No	No
		Non-Network 30%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
5. Dental Services - Accident only Dental services when all of the following are true: • Treatment is necessary because of accidental damage. • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D.". • The dental damage is severe enough that initial contact with a Physician or dentist occurred within 96 hours of the accident. Benefits are available only for treatment of a sound, natural tooth, restored teeth, and prosthesis in good condition to be restored to pre-accident condition. The Physician or dentist must certify to the pre-accident condition of the injured tooth. Dental services for final treatment to repair the damage must be both started within three months of the accident and completed within 12 months of the accident. Oral surgery, full or partial dentures, fixed bridge work, prompt repair to natural teeth, and crowns are covered **only** if needed because of accidental injury and the accident occurred while the Covered Person is covered by this Plan. The least costly, dentally necessary treatment will be considered a Covered Benefit in these circumstances. Dental damage that occurs as a result of normal activities of daily living, such as chewing or eating ice, is not considered an "accident" and repairs to teeth that are injured as a result of such activities are not covered.	***Network and Non-Network*** Yes. Notify the Claims Administrator, and ask for Care Coordination℠, as soon as possible, but at least one business day before post-Emergency treatment begins.	***Network*** 10%	Yes	Yes
		Non-Network 30%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
6. Disposable Medical Supplies Disposable Medical Supplies that meet each of the following criteria: • Ordered or provided by a Physician for outpatient use. • Used for medical purposes to treat a Sickness, Injury or their symptoms. • Not generally useful to a person in the absence of a Sickness, Injury or their symptoms. • Appropriate for use in the home. • Available through a medical supplier and not generally available in grocery or general merchandise stores. Examples of Disposable Medical Supplies include the following: • Two medically appropriate pairs of elastic stockings each year, • Diabetic supplies including the following: — Standard insulin syringes with needles, — Blood testing strips – glucose, — Urine testing strips – glucose, — Ketone testing strips and tablets, — Lancets and lancet devices, — Glucometers (every two years). • Inhaler spacers. • Colostomy bags and supplies. • Intravenous tubing. • Respiratory therapy supplies.	***Network and Non-Network*** No	***Network*** 10% ***Diabetic Supplies*** 0% ***Non-Network*** 30%	No No Yes	Yes No Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Ace bandages. • Gauze and dressings when used with Durable Medical Equipment.				
7. Durable Medical Equipment Durable Medical Equipment that meets each of the following criteria: • Ordered or provided by a Physician for outpatient use. • Used for medical purposes to treat a Sickness, Injury or their symptoms. • Not generally useful to a person in the absence of Sickness, Injury or their symptoms. • Appropriate for use in the home. • Capable of withstanding repeated use. • Not consumable or disposable. • Available through a medical supplier and not generally available in grocery or general merchandise stores. Examples of Durable Medical Equipment include: • Equipment to assist mobility, such as a standard wheelchair. • A standard Hospital-type bed. • Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).	***Network and Non-Network*** Yes. Pre-Notification required for any Durable Medical Equipment over $1,000 whether for purchase or rental.	***Network*** 0% ***Non-Network*** 30%	No Yes	No Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Delivery pumps for tube feedings (including tubing and connectors). • Braces that stabilize an Injured body part and braces to treat curvature of the spine. Orthotic devices that straighten or change the shape of a body part such as arm, leg, neck and back braces are covered, including necessary adjustments to shoes to accommodate braces. However, orthotic shoes or shoe inserts unless attached to a brace and dental braces are excluded from coverage. • Mechanical equipment necessary for the treatment of chronic or acute respiratory failure. We provide Benefits only for a single purchase (including repair/ replacement) of a type of Durable Medical Equipment once every three calendar years unless an additional purchase is required by a change in your physical condition. If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are only available for the most cost-effective piece of equipment. We and the Claims Administrator will decide if the equipment should be purchased or rented. To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor the Claims Administrator identifies.				

Description of Covered Health Service	Must You Notify the Claims Administrator?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
8. Emergency Health Services Services that are required to stabilize or initiate treatment provided by or under the direction of a Physician in an Emergency. An **Emergency** is a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which arises suddenly and in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid placing the patient's life or health in serious jeopardy, causing serious impairment to bodily functions, serious dysfunction of any bodily organ or part or, in the case of a pregnant woman serious disfigurement or serious jeopardy to the health of a fetus. Emergency Health Services are always paid as a Network Benefit. If you seek Emergency care at a Non-Network facility, you are not required to meet the Annual Deductible or to pay any difference between Eligible Expenses and the amount the provider bills.	***Network and Non-Network*** Yes. Notify the Claims Administrator, and ask for Care Coordination℠, on the day of admission or within one business day, or as soon as reasonably possible, but only if an Inpatient Stay is required.	***Network and Non-Network*** $100 per visit which is waived if an Inpatient Stay is required. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the Non-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.	No	No
9. Eye Examinations and Vision Therapy Eye examinations received from a health care provider in the provider's office. Network Benefits include one routine vision exam, including refraction, to detect vision impairment by a Network Provider each calendar year. Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses. Vision therapy (Synonyms include: eye exercise therapy, optometric visual (or vision) therapy, vision training, orthoptic training and pleoptic training)	***Network and Non-Network*** No	***Network*** $35 per visit ***Non-Network*** 30%	No Yes	No Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
10. Home Health Care Services received from a Home Health Agency, a program or organization authorized by law to provide health care services in the home, that are both: • Ordered by a Physician. • Provided by or supervised by a registered nurse in your home. Skilled care includes skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true: • Care is 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. • Care is not delivered to assist with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair. • Care requires clinical training to be delivered safely and effectively. • It is not Custodial Care. Home Health Care includes temporary or part-time care by a home health aide. 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 is not "skilled" simply because there is not an available caregiver.	***Network*** No ***Non-Network*** Yes. Notify the Claims Administrator, and ask for Care Coordination℠, at least one business day before receiving services.	***Network*** 0% ***Non-Network*** 30%	No Yes	No Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
11. Hospice Care Hospice care is an integrated program that provides comfort and support services for the terminally ill who are not expected to live more than six months. 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 recommended by a Physician and received from a licensed hospice agency. Contact the Claims Administrator at the telephone number on your ID Card for more information about guidelines for hospice care.	***Network*** No ***Non-Network*** Yes. Notify the Claims Administrator, and ask for Care Coordination℠ at least one business day before receiving services.	***Network*** 0% ***Non-Network*** 30%	No Yes	No Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
12. Hospital - Inpatient Stay 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 with two or more beds or a private room only if a Semi-private Room is not available or a private room is appropriate in terms of generally accepted medical practice. **Notice requirements for Non-Network Stays:** **Elective admissions:** five business days before admission or as soon as the admission day is set. **Non-elective admissions:** day of admission or within one business day after admission. **Emergency admissions:** day of admission or within two business days after admission, or as soon as is reasonably possible.	***Network*** No ***Non-Network*** Yes. Notify the Claims Administrator, and ask for Care Coordination℠ based on the timeline in adjacent Description of Covered Health Service.	***Network*** $100 per Inpatient Stay plus 10%. ***Non-Network*** $250 per Inpatient Stay plus 30% of Eligible Expenses over $250.	No for $100 Yes for 10% No for $250 Yes for 30%	No for $100 Yes for 10% No for $250 Yes for 30%
Benefits for Physician services are described under Professional Fees for Surgical and Medical Services.				

Description of Covered Health Service	Must You Notify the Claims Administrator?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
13. Injections received in a Physician's Office This Benefit is available when only injections are received in a Physician's office and no other health service is received. When other health services are received, Benefits are described under Physician's Office Services below. Allergists are considered as primary care.	***Network and Non-Network*** No	***Network*** ***For a Primary Care Provider**** $25	No	No
		For a Non-Primary Care Provider* $40	No	No
		*No Copayment applies when there is no Physician charge		
		Non-Network 30% per injection	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
14. Maternity Services Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. There are special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the programs. To sign up, you should notify the Claims Administrator during the first trimester, but no later than one month before the anticipated childbirth. We will pay Benefits for an Inpatient Stay of: • 48 hours for the mother and newborn child following a normal vaginal delivery. • 96 hours for the mother and newborn child following a cesarean section delivery. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.	***Network*** No	***Network*** Copayment and CoInsurance are determined by the type of maternity service and are the same as for other Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services. Copayment applies for the initial visit. No Copayment applies to Physician office visits for routine prenatal care after the first visit. The initial visit to the Network obstetrician who diagnoses pregnancy and is primarily responsible for the Covered Person's maternity care is subject to a Physician's Office Visit Copayment. This Copayment covers all subsequent routine prenatal and post-natal office visits to that Network Physician. All tests after the diagnoses that are recommended by that Network Physician are subject to applicable deductibles and CoInsurance. The Current Procedural Terminology is the guideline for determining whether the procedure is routine or a special service.		

Description of Covered Health Service	Must You Notify the Claims Administrator?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Examples of additional Covered Health Services related to pregnancy are: • Birth Center Services including room and board, anesthetics. • Nurse-Midwife services by a licensed or certified Nurse-Midwife. • Routine Well Baby care before the mother is released from the hospital including nursery care, circumcision by a surgeon and Physician services when the baby is healthy. Services for a healthy new born child during the initial hospital stay if the baby leaves the hospital when the mother is released are covered as part of the mother's pregnancy benefits. Services for a new born child during the initial hospital stay when the new born is not healthy or is not able to leave the hospital when the mother is released are covered as benefits for the child, not as the mother's pregnancy benefits.	***Non-Network*** Yes. Notify the Claims Administrator, and ask for Care Coordination℠ as soon as reasonably possible if Inpatient Stay exceeds time frames.	***Non-Network*** CoInsurance is determined by the type of maternity service and is the same as for other 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?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
15. Mental Health and Substance Abuse Services - Outpatient Mental Health Services and Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including: • Mental health, substance abuse and chemical dependency evaluations and assessment. • Diagnosis. • Treatment planning. • Referral services. • Medication management. • Short-term individual, family and group therapeutic services (including intensive outpatient therapy). • Crisis intervention. For Network Benefits, referrals to a Mental Health/Substance Abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Network Benefits for outpatient Mental Health and Substance Abuse Services. Network and Non-Network Benefits for Mental Health Services and/or Substance Abuse Services are limited to a combined total of 60 visits per calendar year.	***Network and Non-Network*** Mental Health/ Substance Abuse Designee must approve Benefits in advance of any treatment.	***Network*** **For Masters and Ph.D. level Counselors** $20 per individual visit; **For Psychiatrists** $35 per individual visit; ***Non-Network*** 30%	No No Yes	No No Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
16. Mental Health Services - Inpatient and Intermediate Mental Health Services received on an inpatient or intermediate care basis in a Hospital or an Alternate Facility. The Mental Health/Substance Abuse Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. At the discretion of the Mental Health/Substance Abuse Designee, two sessions of intermediate care (such as partial hospitalization) may be substituted for one inpatient day. Network Benefits for Mental Health Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. For Network Benefits, referrals to a Mental Health provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for inpatient/intermediate Mental Health Services.	***Network and Non-Network*** Mental Health/ Substance Abuse Designee must approve Benefits in advance of any treatment.	***Network*** $100 per Inpatient Stay plus 10% ***Non-Network*** $250 per Inpatient Stay plus 30%	No for $100 Yes for 10% No for $250 Yes for 30%	Yes Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
17. Substance Abuse Services - Inpatient and Intermediate Substance Abuse Services received on an inpatient or intermediate care basis in a Hospital or an Alternate Facility. Benefits include detoxification from abusive chemicals or substances that is limited to physical detoxification when appropriate to protect your physical health and well-being. The Mental Health/Substance Abuse Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. At the discretion of the Mental Health/Substance Abuse Designee, two sessions of intermediate care (such as partial hospitalization) may be substituted for one inpatient day. Network Benefits for Substance Abuse Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. For Network Benefits, referrals to a Substance Abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee about Benefits for inpatient/intermediate Substance Abuse Services. Network and Non-Network Benefits for Substance Abuse Services are limited to two admissions of 30 days during a lifetime.	***Network and Non-Network*** Mental Health/ Substance Abuse Designee must approve Benefits in advance of any treatment.	***Network*** $100 per Inpatient Stay plus 10% ***Non-Network*** $250 per Inpatient Stay plus 30%	No for $100 Yes for 10% No for $250 Yes for 30%	Yes Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
18. Outpatient Surgery ***Outpatient Surgery-Facility*** Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility includes only the facility charge and the charge for required Hospital-based professional services, supplies and equipment. Benefits for the surgeon fees related to outpatient surgery are described under Professional Fees for Surgical and Medical Services. ***Outpatient Surgery-Office*** When these services are performed in a Physician's office, Benefits are described under Physician's Office Services below.	***Network and Non-Network*** No	***Network*** 10%	Yes	Yes
		Non-Network 30%	Yes	Yes
19. Outpatient Diagnostic Services Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including: • Lab. • Radiology/X-ray. • Mammography* • CT scans, PET scans, MRI, and nuclear medicine. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a Physician's office, Benefits are described under Physician's Office Services below.	***Network and Non-Network*** No	***Network*** 10%* *The CoInsurance for both Network Diagnostic and Therapeutic Mammography is 0%, the same as if received under Physician's Office Service. The Deductible does not apply for Mammography.	Yes	Yes
		Non-Network 30%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
20. Outpatient Therapeutic Services Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a Physician's office, Benefits are described under Physician's Office Services below.	***Network*** Yes. Notify the Claims Administrator, and ask for Care Coordination[SM] at least one day before dialysis begins No, for all other treatments.	***Network*** 10%	Yes	Yes
	Non-Network No	***Non-Network*** 30%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
21. Physician's Office Services **Physicians may be Primary Care or Non-Primary Care. The areas of Primary Care include:** • General Practice • Family Practice • Pediatrics • Internal medicine • Allergy and Immunology • Obstetrics • Gynecology • Chiropractic medicine • Licensed professional counseling (Masters or Ph.D. level) • Licensed clinical social work (Masters or Ph.D. level) • Psychology (Masters or Ph.D. level) **All other providers are Non-Primary Care providers.**	***Network and Non-Network*** No	***Network*** **For a Primary Care Provider*** $20 per visit **For a Non-Primary Care Provider*** $35 per visit *No Copayment applies when there is no Physician charge ***Non-Network*** 30%	No Yes	No Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Covered Health Services for the diagnosis and treatment of a Sickness or Injury received in a Physician's office.				
Covered Health Services for preventive medical care. Preventive medical care includes: • Voluntary family planning including contraceptive drugs, services and devices like: — Intrauterine devices and related Physician charges; — Physician services related to diaphragm fitting; — Voluntary sterilization by either vasectomy or tubal ligation (diaphragm and oral contraceptive costs are covered under Prescription Drug benefits). For exclusions, see Section 2. • Well-baby and well-child care, including PKU testing. • One routine physical examination for each Covered Person each calendar year. • Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment. See Eye Examinations earlier in this section.) • Immunizations. • Pre-natal and post natal care. • One well woman examination each calendar year including: — Breast examination and mammogram; — Pelvic examination; — Pap smear.				

Description of Covered Health Service	Must You Notify the Claims Administrator?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
22. Professional Fees for Surgical and Medical Services Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls. When these services are performed in a Physician's office, Benefits are described under Physician's Office Services above.	***Network and Non-Network*** No	***Network*** 10%	Yes	Yes
		Non-Network 30%	Yes	Yes
23. Prosthetic Devices External prosthetic devices that replace a limb or an external body part, limited to: • Artificial arms, legs, feet and hands. • Artificial eyes, ears and noses. • Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm. If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device. The prosthetic device must be ordered or provided by, or under the direction of a Physician. Except for items required by the Women's Health and Cancer Rights Act of 1998, Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every three calendar years unless required by physical change in patient's condition.	***Network and Non-Network*** Yes. Notify the Claims Administrator, and ask for Care Coordination℠ for any single Prosthetic Device that costs more than $1,000 (either purchase price or cumulative rental of a single item).	***Network*** 0%	No	No
		Non-Network 30%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
24. Reconstructive Procedures Services for reconstructive surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiological function. Changes or improvements in physical appearance as a result of a reconstructive procedure do not classify it as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves the function of a body part. Cosmetic Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiological function are excluded from coverage. Psychological consequences or socially avoidant behavior to a Covered Person as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve the consequences or behavior as a reconstructive procedure. Benefits for reconstructive surgery include: • removal of scar tissue on the neck, face, or head if the scar tissue is due to Sickness or accidental Injury, • breast reconstruction following a necessary mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women's Health and Cancer Rights Act of 1998, including 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.	***Network*** No ***Non-Network*** Yes. Notify the Claims Administrator, and ask for Care Coordination℠ five business days before receiving reconstructive services. When you provide notification, the Claims Administrator can verify that the service is a reconstructive procedure rather than a Cosmetic Procedure which are always excluded from coverage.	***Network and Non-Network*** Copayment and CoInsurance are determined by the type of service and are the same as for other Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.		

Description of Covered Health Service	Must You Notify the Claims Administrator?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
25. Rehabilitation Services - Outpatient Therapy Short-term outpatient rehabilitation services for: • Physical therapy (limited to three modalities during a visit). • Occupational therapy. • Speech therapy. • Pulmonary rehabilitation therapy. • Cardiac rehabilitation therapy. Rehabilitation services must be performed by a licensed therapy provider in accordance with a written treatment plan, 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. We will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from a defined organic sickness, autism, neurological deficit, Congenital Anomaly or bodily damage not resulting from physical illness, disease, pregnancy, mental illness, or substance abuse.	***Network and Non-Network*** No	***Network*** $5 per visit for the first 20 visits. After the 20th visit, $20 for Primary Care providers and $35 for Non-Primary Care providers. ***Non-Network*** 30%	No Yes	No Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
26. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room with two or more beds or a private room only if a Semi-private Room is not available or a private room is necessary in terms of generally accepted medical practice. 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. Network and Non-Network Benefits are limited to a combined total of 60 days per calendar year.	***Network*** No	***Network*** $100 per Inpatient Stay plus 10%. No Copayment applies if you are transferred to a Skilled Nursing Facility or Inpatient Rehabilitation Facility directly from an acute facility.	No for $100 Yes for 10%	Yes
Notice requirements for Non-Network Stays **Elective admissions**: five business days before admission or as soon as the admission day is set. **Non-elective admissions**: day of admission or within one business day after admission. **Emergency admissions**: day of admission or within two business days after admission, or as soon as is reasonably possible.	***Non-Network*** Yes. Notify the Claims Administrator, and ask for Care Coordination℠ based on timelines in Description of Services	***Non-Network*** $250 per Inpatient Stay plus 30%	No for $250 Yes for 30%	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
27. Spinal Treatment A Spinal Treatment is using manual or mechanical means to detect or correct subluxation in the body to remove nerve interface or its effects. The interference must result from or relate to distortion, misalignment or subluxation of or in the vertebral column. Benefits for Spinal Treatment when provided by a Spinal Treatment provider in the provider's office. Benefits include diagnosis and related services and are limited to three modalities of treatment per day.	***Network and Non-Network*** No	***Network*** $20 per visit ***Non-Network*** 30% Network and Non-Network Benefits for Spinal Treatment are limited to a combined total of 30 visits per calendar year.	No Yes	No Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
28. Transplantation Services 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. The search for bone marrow/stem cell from a donor who is not biologically related to the patient is 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. • Cornea transplants that are provided by a Network Physician at a Network Hospital.	***Network*** Yes*	***Network*** 10%	Yes	Yes
	Non-Network Yes*	***Non-Network*** 30%	Yes	Yes

*Notify the Claims Administrator, and ask for Care Coordination℠, at least seven (7) working days before the evaluation, donor search, organ procurement, and transplant or as soon as the possibility of a transplant arises (and before a pre-transplantation evaluation is performed at a transplant center).

*Notify the Claims Administrator, and ask for Care Coordination℠, as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).

For cornea transplants, Benefits will be paid at the same level as Professional Fees for Surgical and Medical Services, Outpatient Surgery, Diagnostic and Therapeutic Services, and Hospital - Inpatient Stay rather than as described in this section "Transplantation Services."

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage. Contact the Claims Administrator at the telephone number on your ID card for information about the specific guidelines about Benefits for transplant services.

Transportation and Lodging
For all Covered Transplantation Services

Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows if the transplant recipient resides more than 50 miles from the Facility:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
- Eligible Expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $100 per person, up to $200 for two people.
- If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging and meal expenses are paid at a per diem rate of up to $100 per person, up to $300 for three people.

Description of Covered Health Service	Must You Notify the Claims Administrator?	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
The Claims Administrator will assist the patient and family with travel and lodging arrangements. There is a combined overall lifetime maximum Benefit of $10,000 per Covered Person for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures.				
29. Urgent Care Center Services Covered Health Services received at an 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. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under Physician's Office Services earlier in this section.	***Network and Non-Network*** No	***Network*** $25 per visit ***Non-Network*** 30%	No Yes	No Yes

Section 2: What's Not Covered--Exclusions

This section contains information about:

- How headings are used in this section.
- Medical services that are not covered.

How We Use Headings in this Section

To help you find specific exclusions more easily, we use 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 the service is recommended or prescribed by a Physician or is the only available treatment for your condition.

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

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

A. Alternative Treatments

1. Acupressure.
2. Aroma therapy.
3. Hypnotism.
4. Massage Therapy.
5. Rolfing.
6. Ecological or environmental medicine, diagnosis or treatment.
7. Herbal medicine, holistic or homeopathic care, including drugs.
8. 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.
7. Membership costs for health clubs, weight loss clinics, and similar programs.
8. Private Duty Nursing Care as an Inpatient.

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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, except if allowed in Section 1: What's Covered--Benefits under the heading Dental Services - Accident only.)
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. (Prescription Drugs are covered under the Attached Rider.)
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.

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

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.

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 under Section 10 Glossary of Defined Terms.

If a Covered Person has a condition which 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 Experimental, Investigational or Unproven Service meets the definition of a Covered Health Service for the condition if the Claims Administrator determines that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

F. Foot Care, Unless Due to Severe Systemic Disease

1. Routine foot care (including the cutting or removal of corns and calluses). Hygienic and preventive maintenance foot care. Examples include the following:
   - Nail trimming, cutting, or debriding.
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

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— Other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.

2. Treatment of flat feet.
3. Treatment of subluxation of the foot.
4. Shoe orthotics unless attached to a brace.

G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Non-prescribed medical supplies and disposable supplies such as more than two medically appropriate stockings each year.

H. Mental Health/Substance Abuse

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.
2. Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention.
3. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis which are not listed in the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.
4. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.
5. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
6. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee.
7. Non-Network Residential treatment services unless multi-disciplinary treatment is required for the diagnosis or use of a network facility is not practicable due to the unusual circumstances of the patient and the diagnosis.
8. Services of a pastoral counselor.
9. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following:
   — Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
   — Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
   — Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
   — Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time.

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

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

I. Nutrition

1. Megavitamin and nutrition based therapy, chelation therapy, except to treat heavy metal poisoning.
2. Nutritional counseling for either individuals or groups unless due to diabetes or a cardiac condition.
3. Nutritional and electrolyte supplements, including infant formula and donor breast milk and enteral feedings, unless enteral feeding is the only nutrition received.

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.
2. Breast reduction surgery that is determined to be a Cosmetic Procedure.
3. Prophylactic removal of breast, replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure or prophylactic removal of breast implant unless medically appropriate.
   Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed a necessary mastectomy. See Reconstructive Procedures in Section 1: What's Covered--Benefits.
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Special foods, food supplements, liquid diets, diet plans or any related products are excluded.
6. Wigs or toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness regardless of the reason for the hair loss.

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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 ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility unless it is a center of excellence, when that Physician or other provider:
   - — Has not been actively involved in your medical care prior to ordering the service, or
   - — Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography testing.

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L. Reproduction Treatment

1. Health services and associated expenses for infertility treatments.
2. Surrogate parenting.
3. The reversal of voluntary sterilization.
4. Procedures which facilitate a pregnancy but do not treat the cause of infertility, such as in vitro fertilization, artificial insemination, embryo transfer, gamete intrafallopian transfer, zygote intrafallopian transfer, and tubal ovum transfer.

   This exclusion does not apply to diagnoses of infertility.

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 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.

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2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan).
3. Health services for transplants involving mechanical or animal organs.
4. Any solid organ transplant that is performed as a treatment for cancer.
5. Any multiple organ transplants not listed as a Covered Health Service under the heading Transplantation 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 hearing aids, eye glasses or contact lenses.
2. Fitting charge for hearing aids, eye glasses or contact lenses.
3. 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.

Note: Treatment of cataracts is a Covered Health Service.

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.

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

2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
   - — Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
   - — Related to judicial or administrative proceedings or orders.
   - — Conducted for purposes of medical research.
   - — Required to obtain or maintain a license of any type.
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, except for Post Traumatic Stress Disorder.
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 except for services provided while in a confinement that began before coverage ended.
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. If a Non-Network provider waives Copayments, CoInsurance and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, CoInsurance and/or Annual Deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered to be medical or dental in nature.

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9. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.
10. Non-surgical treatment of obesity, including morbid obesity.
11. Surgical treatment of obesity even if morbidly obese with a BMI greater than 35.
12. Growth hormone therapy unless approved by Claims Administrator.
13. Sex transformation operations.
14. Custodial Care which means care that is furnished mainly to train or assist in activities of daily living, instead of providing medical treatment or that can adequately be provided by person who does not have the technical skills of a health care professional.
15. Domiciliary care.
16. Private duty nursing while confined in a facility.
17. Respite care.
18. Rest cures.
19. Psychosurgery.
20. Treatment of benign gynecomastia (abnormal breast enlargement in males).
21. Medical and surgical treatment of excessive sweating (hyperhidrosis).
22. Panniculectomy, abdominoplasty, thighplasty, brachioplasty, mastopexy, and breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reconstruction following a mastectomy as described under Reconstructive Procedures in Section 1: What's Covered—Benefits.

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23. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
24. Oral appliances for snoring.
25. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from a defined organic sickness, autism, neurological deficit, Congenital Anomaly or bodily damage not resulting from physical illness, disease, pregnancy, mental illness, or substance abuse.
26. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
27. Any charge for services, supplies or equipment advertised by the provider as free.
28. Any charges prohibited by federal anti-kickback or self-referral statutes.
29. Services or supplies received before a Covered Person or his or her Dependent becomes covered by this Plan.
30. Education, training, and bed and board while in an institution which is mainly a school, training institution, a place of rest or a place for the aged.
31. Charges made by a Hospital for non-acute care services that may be covered when provided by other appropriate providers for any of the following:
    a. Adult or child day care center.
    b. Ambulatory surgical center.
    c. Birth center.
    d. Half-way house.
    e. Hospice.
    f. Skilled nursing facility.
    g. Treatment center.
    h. Vocational rehabilitation center.

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    i. Any other area where services are not for the acute care of sick, injured or pregnant persons.
32. Telephone consultations.
33. Tobacco dependency.

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Section 3: Description of Network and Non-Network Benefits

This section includes information about:

- Network Benefits.
- Non-Network Benefits.

Network Benefits

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

- Provided by a Network Physician, Network facility, or other Network provider.
- Emergency Health Services.

Mental Health and Substance Abuse Services must be authorized by the Mental Health/Substance Abuse Designee. See Section 1: What's Covered--Benefits under the heading for Mental Health and Substance Abuse.

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

Provider Network

The Claims Administrator arranges for health care providers to participate in a Network. The network of providers is subject to change. It is your responsibility to select your provider. You may check the Network providers through www.myuhc.com or verify the provider's status by calling the Claims Administrator. Before obtaining services you should always verify the Network status of a provider. A provider's status may change.

You might not be able to obtain services from a particular Network provider. A particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

A Network provider's agreement may not include all Covered Health Services. Some Network providers contract to provide only specified Covered Health Services. Refer to your provider directory or contact the Claims Administrator for assistance.

Care Coordination[SM]

Your Network Physician must notify the Claims Administrator about certain proposed or scheduled health services. When your Network Physician notifies the Claims Administrator, they will work together to implement the Care Coordination[SM] process and to provide you with information about additional services available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy.

Other Providers

If you have a medical condition that the Claims Administrator believes needs special services, they may direct you to another provider chosen by them. If you require specified complex Covered

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Health Services for which expertise is limited, the Claims Administrator may direct you to a Non-Network facility or provider.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the provider chosen by the Claims Administrator.

You or your Network Physician must notify the Claims Administrator of special service needs (including transplants or cancer treatment) that might warrant referral to a Designated Facility or a Non-Network facility or provider. If you do not notify the Claims Administrator in advance, and if you receive services from a Non-Network facility or other Non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Plan.

Health Services from Non-Network Providers Paid as Network Benefits

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

Emergency Health Services, including the services of either a Network or Non-Network Emergency room Physician, are always paid as Network Benefits. Covered Health Services provided in a Network facility by a Non-Network consulting Physician, anesthesiologist, pathologist and radiologist will be paid as Non-Network Benefits.

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Non-Network Benefits Exception

You may be eligible to receive Benefits for certain Non-Network Covered Health Services paid at the Network level if you do not have access to a Network provider within a 30 mile radius of your home zip code.

You can check a provider's Network status by visiting www.myuhc.com or by calling the Claims Administrator at the toll-free number on your ID card. We and the Claims Administrator must approve any Benefits payable under this exception before you receive care.

Limitations on Selection of Providers

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

If you don't make a selection within 31 days of the date we notify you, the Claims Administrator will select a single Network Physician for you.

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

Non-Network Benefits

Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits are payable for Covered Health Services that are provided by Non-Network providers.

When accessing Non-Network Services, depending on the geographic area and the service you receive, you may have access

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

through the Claim's Administrator's Shared Savings Program to Non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, even though your CoInsurance for Non-Network Benefits remains the same as it is when you receive Covered Health Services from Non-Network providers who have not agreed to discount their charges, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers, because the Eligible Expense may be less.

Care Coordination[SM]

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

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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.

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

How to Enroll

To enroll, the Eligible Person must complete an enrollment process. The Plan Administrator or its designee will give you notice of the necessary process, along with instructions about enrolling 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 your coverage begins on the day that you are discharged from the Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

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

Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Eligible Person	***Plan for Employees*** Eligible Person refers to an Eligible Employee 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, Eligible Employee, and Participant, see Section 10: Glossary of Defined Terms. If both spouses are Eligible Persons, each must enroll as a Participant. Except as described in Section 4: When Coverage Begins, Eligible Persons may not enroll.	We determine who is eligible to enroll under the Plan.
	Plan for Retirees Eligible Person refers to two types of person who meets the eligibility rules: • Eligible Retiree. • Eligible Survivor. When an Eligible Person actually enrolls, we refer to that person as a Participant. For a complete definition of Eligible Person, Eligible Retiree, Eligible Survivor, and Participant, see Section 10: Glossary of Defined Terms. If both spouses are Eligible Persons, each must enroll as a Participant. Except as described in Section 4: When Coverage Begins, Eligible Persons may not enroll.	We determine who is eligible to enroll under the Plan.

Who	Description	Who Determines Eligibility
Dependent	***Plan for Employees*** Dependent refers to five types of person who meets the eligibility rules: • Participant's Spouse • Participant's Children. • Participant's Grandchild. • Domestic Partner. • Domestic Partner's Children if Domestic Partner is covered. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent, Participant's Spouse, Participant's Children, Domestic Partner, Domestic Partner's Children, and Enrolled Dependent, see Section 10: Glossary of Defined Terms. Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan. If both parents of a child are enrolled as a Participant, only one parent may enroll the child as a Dependent. Except as described in Section 4: When Coverage Begins, Dependents may not enroll unless eligible under a qualified change in status.	We determine who qualifies as a Dependent.
	Plan for Retirees Dependent refers to three types of person who meets the eligibility rules: • Participant's Spouse • Participant's Children. • Participant's Grandchild. Dependents must either be continuously enrolled from the date of retirement of the Eligible Retiree or Eligible Survivor or from October 1, 2005, whichever is later. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent, Participant's Spouse, Participant's Children, and Enrolled Dependent, see Section 10: Glossary of Defined Terms. Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan. If	We determine who qualifies as a Dependent.

Who	Description	Who Determines Eligibility
	both parents of a Dependent child are enrolled as a Participant, only one parent may enroll the child as a Dependent. Except as described in Section 4: When Coverage Begins, Dependents may not enroll unless eligible under a qualified change in status.	

When to Enroll and When Coverage Begins

When to Enroll	Who Can Enroll	Begin Date
Annual Enrollment Period		
Plan for Employees The Annual Enrollment Period is the 30 day period during which an Eligible Person may select the benefit coverages he or she will receive during the following Plan Year.	Eligible Persons may enroll themselves and their Dependents. Eligible Employees may enroll a Domestic Partner. Eligible Employees may only enroll one adult as a Dependent.	The Plan Sponsor determines the Annual Enrollment Period. Coverage begins on October 1st if the Eligible Person completes the enrollment process within 31 days of the date Annual Enrollment begins.
Plan for Retirees The Annual Enrollment Period is the 30 day period during which an Eligible Person may select the benefit coverages he or she will receive during the following Plan Year. The Eligible Person may select the Choice Plus Plan for Travis County Retirees, the Choice Plan for Travis County Retirees or the Coinsured Choice Plan for Travis County Retirees.	Eligible Persons may enroll themselves and, if their Dependents have been continuously enrolled from the date of the retirement of the Eligible Retiree or Eligible Survivor or from October 1, 2005, they may enroll their Dependents.	The Plan Sponsor determines the Annual Enrollment Period. Coverage begins on October 1st if the Eligible Person completes the enrollment process within 31 days of the date Annual Enrollment begins.

When to Enroll	Who Can Enroll	Begin Date
Newly Eligible Persons		
Plan for Employees These are newly hired Eligible Employees.	Newly Eligible Persons may enroll themselves and their Dependents. Newly Eligible Employees may enroll a Domestic Partner. Eligible Employees may only enroll one adult as a Dependent.	Coverage for newly Eligible Employees begins on the first day of the month following the completion of a 30 day waiting period if the Eligible Person properly completes the enrollment process within 30 days of the date the newly Eligible Person becomes eligible to enroll.
Plan for Retirees These are newly retired Eligible Retirees and newly Eligible Survivor.	Newly Eligible Persons may enroll themselves and their Dependents if they have been enrolled prior to retirement and remained continuously enrolled after retirement or since October 1, 2005, whichever is later.	Coverage for newly retired Eligible Retirees and newly Eligible Survivors begins immediately.
Adding New Dependents		
Plan for Employees Other than Annual Enrollment Periods, new Dependents can only be added when the proposed person satisfies all criteria for that type of dependent.	Participants may enroll Dependents when they meet the criteria: • Domestic Partner. Eligible Employees may only enroll one adult as a Dependent.	Coverage begins on the first day of the first month after all criteria are met, if the Eligible Person requests and completes an enrollment process within 30 days of meeting all the criteria.

Plan for Retirees

New Dependents cannot be enrolled after they are newly eligible.

Special Enrollment Period

Plan for Employees

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

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

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

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

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

- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Annual Enrollment Period or when newly eligible; and

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Birth or Adoption. Coverage begins on the date of the birth or adoption if the Eligible Person completes the enrollment process within 30 days of the birth or adoption.

Marriage. Coverage begins on the first day of the month after the marriage if the Eligible Person completes the enrollment process within 30 days of the event.

Loss of Other Coverage. Coverage begins on the first day of the month after the loss of coverage event date if the Eligible Person completes the enrollment process within 30 days of the event.

Legal Guardianship. Coverage begins on the first day of the month following a full 30 days if the Eligible Person completes the enrollment process within 30 days of the event.

Court or Administrative Order. Coverage begins on the date noted on the court order.

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 is exhausted.	

Plan for Retirees

There is no special enrollment for retirees or their dependents.

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 meeting the Annual Deductible and for paying Copayments and CoInsurance to a Network provider at the time of service, or when you receive a bill from the provider.

Filing a Claim for Non-Network Benefits

When you receive Covered Health Services from a Non-Network provider, you must request payment from us through the Claims Administrator.

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If you don't submit a request for payment of Benefits within 12 months after the date of service, Benefits for that health service will be denied unless it was not reasonably possible to file the claim within 12 months and proof is given as soon as possible. (This time limit does not apply if you are legally incapacitated.) If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

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

A. Participant's name and address.
B. The patient's name, age and relationship to the Participant.
C. The member number stated on your ID card.
D. An itemized bill from your provider that includes the following:
   - Patient diagnosis
   - Date of service or supplies incurred
   - Procedure code(s) and description of service(s) rendered
   - Provider of service (Name, Address and Tax Identification Number)
E. The date the Injury or Sickness began.
F. A statement indicating whether you are 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).

Benefit Determinations

Through the Claims Administrator, we will make a benefit determination.

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Urgent Requests for Benefits that Require Immediate Action

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

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

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

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

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

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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 appeal procedures.

Post-Service Claims

Post-Service Claims are claims that are filed 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 you don't provide the needed information within 45-days, your claim will be denied.

If all of the needed information is received within the 45-days and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received.

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

Pre-Service Requests for Benefits

Pre-service requests for Benefits are requests that require notification or approval before receiving medical care. If your pre-service request for Benefits was submitted properly with all needed information, you will receive written notice of the decision from the Claims Administrator within 15 days of receipt of the request. If you did not file a pre-service request for Benefits properly, the Claims Administrator will notify you of how to correct it within 5 days after

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the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, the Claims Administrator will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15 days and pend your request until all information is received. You then have 45 days to provide this information. If you don't provide the needed information within 45 days, your claim will be denied. If all of the needed information is received within 45 days, the Claims Administrator will notify you of the determination within 15 days after the information is received. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for Benefits, your request will be decided within 24 hours, provided your request is made at least 24 hours before 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 before the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the urgent request timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

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Benefit Determinations

You may not assign your Benefits under the Plan to a Non-Network provider without our consent. The Claims Administrator may, however, in its discretion, pay a Non-Network provider directly for services rendered to you.

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Section 6: Questions, Complaints 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 have a complaint.
- How to handle an appeal that requires immediate action.
- You are notified that a claim has been denied because it has been determined that a service or supply is excluded under the Plan and you wish to appeal such determination.

What to Do First

If your 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 concern in writing. If you are not satisfied with a benefit determination as described in Section 5: How to File a Claim, you may appeal it without informally contacting Customer Service. 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, refer to the "Urgent Appeals that Require Immediate Action" section below and contact Customer Service immediately.

The Customer Service telephone number is shown on your ID card.

How to Appeal a Claim Decision

If you disagree with a pre-service request for Benefits determination or post-service claim determination after following the steps in Section 5, you can contact the Claims Administrator in writing to formally 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.

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

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Appeal Process to Claims Administrator

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

Appeals Determinations

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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First Level Appeals

Pre-Service Requests for Benefits Appeals

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

For appeals of pre-service requests for Benefits as defined in Section 5: 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 request for Benefits.

Post-Service Requests for Benefits Appeals

For appeals of post-service claims as defined in Section 5: 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.

Second Level Appeals to Plan Sponsor

If you are dissatisfied with the Claims Administrator's decision, you may appeal that decision to the Plan Sponsor. You may not appeal that decision until all appeal procedures available through the Claims Administrator have been exhausted.

You must file your appeal to the Plan Sponsor with its Risk and Benefit Manager at its Human Resources Management Department within 60 days after you receive the first level appeal decision of coverage for Health Services from the Claims Administrator. The appeal must be in writing and must include at least the following information and authorizations:

- Your name and social security number
- The name of the person whose care is being appealed
- The name and address of the medical providers involved

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- A clear statement of the level of service requested and the amount of indemnity requested
- A detailed explanation of the reason that the appeal should be considered
- Copies of all documents previously submitted for consideration to the Claims Administrator for its review of its decision not to approve coverage for Health Services
- An authorization for release of medical information to the Risk and Benefit Manager, the Appeals Committee panel hearing the appeal, and the County Attorney advising the panel, and
- An authorization for review and discussion of medical information to the Risk and Benefit Manager, the Appeals Committee panel hearing the appeal, and the County Attorney advising the panel as necessary to hear and determine the appeal.

The appeal should be enclosed in a sealed envelope or a sealed box and marked "Confidential Appeal" to notify the Plan Sponsor that the contents should be kept confidential. If the appeal is marked "Confidential Appeal", it will only be opened by the Risk and Benefit Manager or the Director of the Human Resources Management Department.

Within five businesses days after receipt of an appeal, the Risk and Benefit Manager will establish an Appeal Committee panel of three members from the Appeals Committee appointed by the Commissioners Court. This panel will include at least one licensed medical practitioner with expertise that is appropriate to the medical issue being appealed and the Risk and Benefit Manager or his representative. The Risk and Benefit Manager will set the time, location, and agenda for the Appeals Committee hearing and post Open Meetings notices.

The panel will review the information you submitted and hold a hearing to make a decision about the appeal. A representative of the

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County Attorney may also attend the appeal hearing but cannot vote on the appeal.

The Appeals Committee panel must issue a written decision with reasons for its decision within 7 business days after the Risk and Benefit Manager receives the complete written appeal. Written decisions of a panel of the Appeal Committee will not include any information that identifies who you are, like your name or social security number. This 7 business days does not begin until you have provided all of the required information.

Meetings of an Appeals Committee panel must comply with the Texas Open Meetings Act. Notice of meetings must be posted and the panel may go into closed session to discuss the appeal.

You may present information to the Appeals Committee panel at the hearing in both open and closed session. If you present the information in writing, you can preserve the confidentiality of your identity. If you choose to present information orally in person in open session at the hearing of the panel, the fact that you presented the information in this manner acts as a release of the medical information presented to everyone at the open session of the hearing and a waiver of any right you would otherwise have to confidentiality of your identity.

You will be allowed to be present in the closed session unless the panel needs to receive legal advice about the appeal. You will not be allowed to be present for any legal advice that is provided in closed session.

All written information you provide in the appeal, all oral information you provide in closed session at the hearings, and all discussions about any appeal by the Appeal Committee panel must be kept confidential.

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The Plan Sponsor must notify you of the second level appeal decision within 30 days after receiving the second level appeal from you.

The Plan Sponsor has the exclusive right to interpret and administer the Plan. The decision of the Appeals Committee panel is final. There is no further appeal of this decision.

The Plan Sponsor'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.

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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. 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 determine which Coverage Plan will pay as the Primary Coverage Plan. The Primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some expenses. A Secondary Coverage Plan pays after the Primary Coverage Plan and may reduce the benefits it pays. This is to prevent payments from all group Coverage Plans from exceeding 100 percent of the total Allowable Expense.

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NOTE: This Coordination of Benefits provision does not apply to Prescription Drug Products covered through this Plan.

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, or no-fault, benefits under group or individual automobile contracts; medical benefits coverage under homeowner's insurance; 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.

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

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

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

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

   a. If a Covered Person is confined in a private Hospital room, the difference between the cost of a Semi-private Room in the Hospital and the private room is not an Allowable Expense 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.

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

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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;

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

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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 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.

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

Effect on the Benefits of this Plan

A. When this Coverage Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Coverage Plans during a claim determination period are not more than 100 percent of total Allowable Expenses. As each claim is submitted, this Coverage Plan will determine its obligation to pay or provide benefits under its contract.

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

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

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

1. 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.

2. 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.

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3. 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.

4. 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.

5. The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

Right to Receive and Release Needed Information

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

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

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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 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).

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

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 after 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
Entire Plan Ends	Your coverage ends on the date the Plan ends. We are responsible for notifying you that your coverage has ended.
You Are No Longer Eligible	Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Participant or Enrolled Dependent. See Section 10: Glossary of Defined Terms for a more complete definition of the terms "Eligible Person", "Eligible Employee", "Eligible Retiree", "Eligible Survivor", "Participant", "Dependent" and "Enrolled Dependent".
Claims Administrator Receives Notice to End Coverage	Your coverage ends on the last day of the calendar month in which the Claims Administrator receives written notice from us instructing the Claims Administrator to end your coverage, or the date requested in the notice, if later.
Participant Retires	Your coverage as an Eligible Employee ends the last day of the calendar month in which the Participant is retired if you do not enroll as an Eligible Retiree under the Plan. We are responsible for providing written notice to the Claims Administrator to end your coverage. This provision applies for retired persons, only if the Participant continues to meet any applicable eligibility requirements and makes the required premium payments.

Other Events Ending Your Coverage

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

Ending Event	What Happens
Fraud, Misrepresentation or False Information	Fraud or misrepresentation, or because the Participant knowingly gave us or the Claims Administrator false material information. Examples include false information relating to another person's eligibility or status as a Dependent. We have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.
Material Violation	There was a material violation of the terms of the Plan.
Improper Use of ID Card	You permitted an unauthorized person to use your ID card, or you used another person's card.
Failure to Pay	You failed to pay a required contribution.
Threatening Behavior	You committed acts of physical or verbal abuse that pose a threat to our staff, the Claims Administrator's staff, a provider, or other Covered Persons.

Coverage for a Handicapped Child

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:

- Enrolled Dependent child is not able to be self-supporting because of mental retardation or physical handicap.
- Enrolled Dependent child 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 Claims 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 Claims Administrator agrees to this extension of coverage for the child, the Claims Administrator may require that a Physician chosen by us examine the child. We will pay for that examination.

The Claims Administrator may continue to ask you for proof that the child continues to meet these conditions of incapacity and dependency. This 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 Claims Administrator's request as described above, coverage for that child will end.

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Continuation Coverage under Federal Consolidated Omnibus Budget Reconciliation Act ("COBRA")

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 Spouse who is an Enrolled Dependent.
- A Participant's Child who is an Enrolled Dependent, including a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law.
- A Participant's former legal spouse, at the time of separation or divorce.

A Domestic Partner, a Domestic Partner's Child, and a Sponsored Dependent are not Qualified Beneficiaries.

Qualifying Events for Continuation Coverage under 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.

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

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

With respect to a Participant's Spouse or Participant's Child who is a Qualified Beneficiary, the qualifying events are:

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

Notification Requirements and Election Period for Continuation Coverage under COBRA

Notification Requirements for Qualifying Event

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

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

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

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

Notification Requirements for Disability Determination or Change in Disability Status

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

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

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

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

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

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Participant will lose these special COBRA rights. COBRA coverage elected during the special second election period is not

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retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period

Terminating Events for Continuation Coverage under 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 events A and B).

   If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at any time within the first 60 days of continuation coverage for qualifying event A or B, then the Qualified Beneficiary may elect an additional eleven months of continuation coverage (for a total of twenty-nine months of continued coverage) subject to the following conditions:

   6. Notice of such disability must be provided within the latest of 60 days after:

      a. the determination of the disability; or
      b. the date of the qualifying event; or
      c. the date the Qualified Beneficiary would lose coverage under the Plan; and
      d. in no event later than the end of the first eighteen months.

   7. The Qualified Beneficiary must agree to pay any increase in the required premium for the additional eleven months.

   8. If the Qualified Beneficiary who is entitled to the eleven months of coverage has non-disabled family members who

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are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional eleven months of continuation coverage.

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

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

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

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

   2. Thirty-six months from the date of the Participant's Medicare entitlement, if a second qualifying event (that was due to either the Participant's termination of employment or the Participant's work hours being reduced) occurs prior to the expiration of the eighteen months.

D. For Qualified Beneficiaries, and to the extent that the Participant became entitled to Medicare subsequent to the qualifying event:

   1. Thirty-six months from the date of the Participant's termination from employment or work hours being reduced (first qualifying event) if:

      a. The Participant's Medicare entitlement occurs within the eighteen month continuation period; and

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      b. Absent the first qualifying event, the Medicare entitlement would have resulted in a loss of coverage for the Qualified Beneficiary under the group health plan.

E. The date coverage terminates under the Plan for failure to make timely payment of the premium.

F. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

G. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event G). If the Qualified Beneficiary was entitled to continuation because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event G) and the retired Participant dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for thirty-six months from the date of the Participant's death.

H. The date the entire Plan ends.

I. The date coverage would otherwise terminate under the Plan as described in this section under the heading Events Ending Your Coverage.

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Section 9: General Legal Provisions

This section provides you with information about:
- General legal provisions concerning the Plan.

Plan Document

This SPD is part of the official plan documentation and represents an overview of your medical and pharmacy Benefits. The Claims Administrator administers for medical and pharmacy benefits in accordance with the SPD. The official plan documentation includes information not found in the medical SPD such as other employee benefits that may be available to you (e.g., dental, FSA, life, disability etc.) and associated benefit communications including insurance policies, certificates, booklets, benefit brochures, employee web site information, and enrollment guides. In the event there is a discrepancy between the SPD and the official plan documentation, the plan documentation governs. A copy of the plan documentation is available upon written request from the Plan Administrator. You (or your personal representative) may obtain a copy of this documentation, for a nominal charge, by written request to the Plan Administrator.

Our 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.

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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. We do not have any other relationship with Network providers such as principal-agent or joint venture. Neither we nor the Claims Administrator are liable for any act or omission of any provider.

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

We are solely responsible for all of the following:

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

Your Relationship with Providers

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

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

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

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

Incentives to Providers

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

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

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

Rebates and Other Payments

We and the Claims Administrator may receive rebates for specified drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. We and the Claims Administrator do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copayments and CoInsurance.

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 specified 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

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we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

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

Amendments to the Plan

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 federal statutes or regulations, or applicable state law provisions not otherwise preempted by the Public Health Service Act 42 U.S.C. 300bb-3 (of the jurisdiction in which the Plan is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

Any change or amendment to or termination of the Plan, its benefits or its terms and conditions, in whole or in part, shall be made solely in a written amendment to the Plan (in the case of a change or amendment) or in a written resolution (in the case of a termination), whether prospective or retroactive, in accordance with the procedures established by us. Covered Persons will receive notice of

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

Information and Records

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

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

We and the Claims Administrator have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate

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medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Plan, we, the Claims Administrator, and our related entities may use and transfer the information gathered under the Plan for research and analytic purposes.

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

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

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

Examination of Covered Persons

If there is a question or dispute about your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

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

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

Medicare Eligibility

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

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

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you **should** enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, we will assume the position of a secondary payer as described in Section 7: Coordination of Benefits, and 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.

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Subrogation and Reimbursement

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

Right to Subrogation

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

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

Right to Reimbursement

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

Third Parties

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- The Plan Sponsor.

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- 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.
- The Plan may enforce its subrogation and reimbursement rights regardless of whether you have been "made whole" (fully compensated for your injuries and damages).
- You will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - Complying with the terms of this section.

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— Providing any relevant information requested.

— Signing and/or delivering documents at its request.

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

— Obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.

- If you receive payment as part of a settlement or judgment from any third party as a result of a Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- You will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a Sickness or Injury caused by a third party.
- The Plan's rights will not be reduced due to your own negligence.
- The Plan may file suit in your name and take appropriate action to assert its rights under this section. The Plan is not required to pay you part of any recovery it may obtain from a third party, even if it files suit in your name.
- The provisions of this section apply to the parents, guardian, or other representative of an Enrolled Dependent child who incurs a Sickness or Injury caused by a third party.

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- In case of your wrongful death, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs.
- Your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.
- If a third party causes you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Covered Person.

Refund of Overpayments

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

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

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

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The

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reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

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 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 and that provides one or more of the following services on an outpatient basis, as permitted by law:

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

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

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

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.

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Cancer Resource Services Program - the program made available by the Plan Sponsor to Participants. The Cancer Resource Services Program provides information to Participants or their Enrolled Dependents with cancer and offers access to additional cancer centers for the treatment of cancer.

Child - an unmarried dependent child of the Participant or Participant's spouse, under 26 years of age who is primarily dependent upon the Eligible Employee for support and maintenance and who is not regularly employed on a full time basis for 30 hours or more per week. The term child includes any of the following:

- A natural child.
- A stepchild.
- A grandchild who resides in the Participant's home and for whom a validly executed and notarized guardianship document has been submitted to Human Resources Management Division.
- A legally adopted child.
- A child placed for adoption.

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

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

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Claims Administrator - the company (including its affiliates) that provides specified 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 after birth.

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

A Covered Health Service is a health care service or supply or equipment 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 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, and the services do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

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Dependent - the Participant's Spouse or a Participant's Child or Participant's Domestic Partner or Domestic Partner's Child if the Domestic Partner is covered.

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

Dependents must live in the United States.

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.

Domestic Partner - a person who meets all of the following conditions:

- Not employed by the Eligible Employee.
- Not related to the Eligible Employee by marriage.
- Not currently married to, or a Domestic Partner of, another person under either statutory or common law.
- Sharing the same residence and the common necessities of life with the Eligible Employee for at least six months before applying for coverage and currently living with the Eligible Employee.
- Having a relationship with the Eligible Employee that includes shared expenses and shared responsibilities for the maintenance and operation of their shared residence

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- Having provided Plan Sponsor with an Affidavit of Domestic Partnership that includes the names of any child for whom coverage is sought.
- Not in active service in the armed forces.
- At least 18 years of age.

A Domestic Partner is not dependent for the purpose of determining a qualified beneficiary as defined in COBRA. Domestic Partners are not eligible for COBRA continuation.

Domestic Partner's Child - a Child of Eligible Employee's Domestic Partner who has been living with the Eligible Employee for at least six months before applying for coverage and is currently living with the Eligible Employee if the Domestic Partner is covered. The term Domestic Partner's Child also includes a child for whom legal guardianship has been awarded to the Participant's Domestic Partner.

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

A Domestic Partner's Child is not dependent for the purpose of determining a qualified beneficiary as defined in COBRA. A Domestic Partner's Child is not eligible for COBRA continuation.

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

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

- When Covered Health Services are received from Network providers, Eligible Expenses are the contracted fee(s) with that provider.

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- When Covered Health Services are received from Non-Network providers as a result of an Emergency or as otherwise arranged through the Claims Administrator, Eligible Expenses are billed charges unless a lower amount is negotiated.

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

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

Eligible Person –

Plan for Travis County Employees - an Eligible Employee.

Eligible Persons must live in the United States.

Plan for Travis County Retirees - an Eligible Retiree, or an Eligible Survivor.

Eligible Persons must live in the United States.

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Eligible Employee - a current regular full-time employee of the Plan Sponsor who is scheduled to work at his or her job at least 20 hours per week.

Eligible Retiree - a person who meets all of the following conditions:

- terminated or retired from Plan Sponsor
- receiving annuity benefits from the Texas District and County Retirement Association due to employment with Plan Sponsor
- either:
  - — continuously covered by a Plan for Retirees or a former Plan for Retirees since termination or retirement, or
  - — covered as a retiree on October 1, 2005 and continuously covered by a Plan for Retirees or a former Plan for Retirees since then.

Eligible Survivor - either of the following:

- A surviving spouse of any person who was receiving annuity benefits from the Texas District and County Retirement Association due to employment with Plan Sponsor if the surviving spouse was covered by the Plan or the former Plan of the Plan Sponsor at the time of the retired person's death and has maintained continuous coverage since the date of the retired person's death, or
- A person who qualifies as an eligible survivor under Subchapter D, Chapter 615 of TEX. GOV'T CODE ANN.

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

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

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- 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.

Hospital - an institution, operated as required by law, that is all 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.
- Is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations.
- Is approved by Medicare as a Hospital.
- Is operated continuously with organized facilities for operative surgery on the premises.

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

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

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

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

Medicare - Parts A, B, C and D 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 Mental Disorders* published by the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

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

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of Mental Disorders* published by 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

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(either directly or indirectly) with the Claims Administrator or with the Claims Administrator's affiliate to participate in the Claims Administrator's Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with them through common ownership or control with the Claims Administrator or with its ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only specified Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of the Claims Administrator's products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a Non-Network provider for other Covered 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, Network facility, or other Network provider.

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

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.

Participant's Child - a Child of the Participant or the Participant's Spouse. The term Participant's Child also includes a child for whom legal guardianship has been awarded to the Participant or the Participant's Spouse.

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

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

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

Plan - Choice Plus for Travis County Employee Health Benefit Fund Plan.

Plan Administrator - Travis County or its designee.

Plan Sponsor - Travis County. 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.

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.

Shared Savings Program - the Shared Savings Program provides access to discounts from the provider's charges when services are

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rendered by those Non-Network providers that participate in that program. The Claims Administrator will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. The Claims Administrator does not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by Non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When the Claims Administrator uses the Shared Savings Program to pay a claim, patient responsibility is limited to Copayments calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.

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

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

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

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

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

Working Day - any business day for County and does not include Saturday, Sunday or County holidays.

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Riders, Amendments, Notices

Outpatient Prescription Drug Rider

Attachment I

Attachment II

Choice Plus

Outpatient Prescription Drug Rider

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Outpatient Prescription Drug Rider

This Rider to the SPD provides Benefits for outpatient Prescription Drug Products. Benefits are provided for outpatient Prescription Drug Products at a Network Pharmacy.

Certain capitalized words have special meanings. We have defined these words in Section 10: Glossary of Defined Terms of the SPD and in Section 3: Glossary of Defined Terms of this Rider.

"We," "us," and "our" in this document refer to Plan Sponsor. "You" and "your" refer to people who are Covered Persons as the term is defined in the SPD Section 10: Glossary of Defined Terms.

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

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Introduction

Benefits for Outpatient Prescription Drug Products

Benefits are available for Outpatient Prescription Drug Products at a Network Pharmacy and are subject to Copayments. There is no coverage for Prescription Drugs dispensed at a Non-Network Pharmacy.

Identification Card (ID Card) - Network Pharmacy

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

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment and any deductible that applies.

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Designated Pharmacies

If you require certain Prescription Drug Products, the Claims Administrator may direct you to a Designated Pharmacy with whom we have an exclusive arrangement to provide those Prescription Drug Products.

In this case, Benefits will only be paid if your Prescription Order or Refill is obtained from the Designated Pharmacy.

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Rebates and Other Payments

We and the Claims Administrator may receive rebates for certain drugs included on the Prescription Drug List. We or the Claims Administrator do not pass these rebates on to you, nor are they taken into account in determining your Copayments.

The Claims Administrator, and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this Outpatient Prescription Drug Rider. Such business may include data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Outpatient Prescription Drug Rider. The Claims Administrator is

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not required to pass on to you, and does not pass on to you, such amounts.

Coupons, Incentives and Other Communications

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

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

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

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

Benefits for Outpatient Prescription Drug Products

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

When a Brand-name Drug Becomes Available as a Generic

When a Generic becomes available for a Brand-name Prescription Drug Product, your Copayment may change. You will pay the Copayment applicable for a Brand-name Prescription Drug with a Generic Prescription Drug available.

Supply Limits

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

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

Notification Requirements

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

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

Network Pharmacy Notification

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

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

If the Claims Administrator is not notified before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy.

Pharmacy Benefit Claims

If you are asked to pay the full cost of a prescription when you fill it at a Network Retail or mail-order pharmacy and you believe that the Plan should have paid for it, you may submit a claim for reimbursement as a post-service group health plan claim. If you pay a Copayment and you believe that the amount of the Copayment was incorrect, you also may submit a claim for reimbursement as a post-service group health plan claim.

If a Network Retail or mail order pharmacy fails to fill a prescription that you have presented, you may contact the Claims Administrator by submitting a claim for coverage as a pre-service health plan claim.

You may seek information regarding claims in Section 5: How to File a Claim, and information on appeals in the SPD Section 6 Questions, Complaints and Appeals.

When you submit a claim on this basis, you may pay more because you did not notify the Claims Administrator before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost (for Prescription Drug Products from a Network Pharmacy), less the required Copayment and any deductible that applies.

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

Specialty Prescription Drug Product

If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an exclusive arrangement to provide those Prescription Drug Products. In this case, benefits will only be paid if your Prescription Order or Refill is obtained from the Designated Pharmacy.

What You Must Pay

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

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

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

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Payment Information

Payment Term	Description	Amounts
Copayment	Copayments for a Prescription Drug Product at a Network Pharmacy are a specific dollar amount. Your Copayment is determined by the type of Prescription Drug Product. Copayments for compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are determined by the category that applies to the main active ingredient in the drug.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment or • The Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug Product. For Prescription Drug Products from a home delivery Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment or • The Prescription Drug Cost for that Prescription Drug Product. ***See the Copayments stated in the Benefit Information table for amounts.*** Drugs which are prescribed, dispensed, or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility are not subject to a Copayment.

Description of Pharmacy Type and Supply Limits	Your Copayment Amount
Prescription Drugs from a Retail Network Pharmacy Benefits are provided for outpatient Prescription Drug Products dispensed by a retail Network Pharmacy. The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Copayment for each cycle supplied. If your physician orders or approves filling your Prescription Drug Order so that you must split the tablets provided to get the appropriate dosage, your Copayment is **half** of the Copayment for the type of Prescription Drug Product prescribed that is shown in the adjacent column.	\$10.00 per Prescription Order or Refill for a **Generic Prescription Drug Product**. \$25.00 per Prescription Order or Refill for a **Brand-Name Prescription Drug Product** when a generic equivalent is not available. \$45.00 per Prescription Order or Refill for a **Brand-Name Prescription Drug Product** when a generic equivalent is available and when provided to a Covered Person who is not a retiree or retiree's dependent **and Specialty Prescription Drug Products** when purchased from a Designated Pharmacy regardless of retiree status. \$35.00 per Prescription Order or Refill for a **Brand-Name Prescription Drug Product** when a generic equivalent is available and when provided to an Eligible Retiree Participant or that retiree's dependent.

Prescription Drug Products from a Home Delivery Network Pharmacy

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

- As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a home delivery Copayment for any Prescription Orders or Refills sent to the home delivery pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or refill for a 90-day supply, not a 30-day supply with three refills.

If your Prescription Drug Order is written so that you must split the tablets provided to get the appropriate dosage, your Copayment is **half** of the Copayment for the type of Prescription Drug Product prescribed that is shown in the adjacent column.

For up to a 90-day supply, your Copayment is:

$20.00 per Prescription Order or Refill for a **Generic Prescription Drug Product**.

$50.00 per Prescription Order or Refill for a **Brand-Name Prescription Drug Product** when no generic equivalent is available.

$90.00 per Prescription Order or Refill for a **Brand-Name Prescription Drug Product** when a generic equivalent is available and when provided to a Covered Person who is not a retiree or retiree's dependent **and Specialty Prescription Drug Product** when purchased from a Designated Pharmacy regardless of retiree status.

$70.00 per Prescription Order or Refill for a **Brand-Name Prescription Drug Product** when a generic equivalent is available and when provided to an Eligible Retiree Participant or that retiree's dependent.

Section 2: What's Not Covered--Exclusions

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

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

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17. Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill.
18. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug. Prescription Drug Products that are comprised of components that are available in over-the-counter form or equivalent.
19. New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by the Claims Administrator's Prescription Drug List Management Committee.
20. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

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Section 3: Glossary of Defined Terms

This section:

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

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

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

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

Network Pharmacy - a pharmacy that has:

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

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

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

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

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

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

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - Standard insulin syringes with needles;
  - Blood-testing strips - glucose;
  - Urine-testing strips - glucose;
  - Ketone-testing strips and tablets;
  - Lancets and lancet devices;
  - Glucose monitors.

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

Specialty Prescription Drug Product **-** Prescription Drug Products that are identified by Plan Administrator as a Specialty Drug, which are generally high cost, biotechnology or genetically-engineered drugs used to treat patients with certain illnesses.

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

- End of Outpatient Prescription Drug Rider -

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Attachment I

Women's Health and Cancer Rights Act of 1998

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

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

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

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

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

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

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Attachment II

Travis County Employee Health Benefit Fund Plan Document

The Use and Disclosure of Protected Health Information and Security of Electronic Protected Health Information

Under the federal privacy regulations enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your health plans are required to protect the confidentiality of your Protected Health Information. Protected Health Information (PHI) is individually identifiable health information related to your condition, services provided to you, or payments made for your care, which is created or received by a health plan, a health care clearinghouse, or a health care provider that electronically transmits such information. Travis County Employee Health Benefit Fund and Travis County, Texas will not use or disclose health information protected by HIPAA, except for treatment, payment, health plan operations (collectively known as "TPO"), as permitted or required by other state and federal law, or to business associates to help administer the Plan.

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All disclosures of the PHI by a health insurance issuer or HMO to the Plan Sponsor will comply with the restrictions and requirements set forth in the Plan and in the "504" provisions.

The Plan may not, and may not permit a health insurance issuer or HMO, to disclose members' PHI to the Plan Sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of

- Obtaining premium bids from health plans for providing health insurance coverage under the Plan, or
- Modifying, amending, or terminating the Plan.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the "504" provisions.

Further, Travis County, Texas will take reasonable steps to ensure that any use or disclosure is the minimum necessary to accomplish the task.

In addition, under the federal security regulations enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your health plans are required to safeguard the confidentiality and ensure the integrity and availability of your Electronic Protected Health Information. Electronic Protected Health Information (ePHI) is PHI that is maintained or transmitted in electronic form. Travis County Employee Health Benefit Fund and Travis County, Texas will reasonably and appropriately

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safeguard ePHI created, received, maintained, or transmitted to or by Travis County, Texas on behalf of the Plan.

The Plan and Travis County, Texas exchange information to coordinate your Plan coverage. Travis County, Texas agrees to and has certified that it will:

- Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;
- Ensure that any agents, including subcontractors, to whom it provides PHI received from Travis County Employee Health Benefit Fund agree to the same restrictions and conditions that apply to Travis County, Texas with respect to such information;
- Not use or disclose PHI for employment-related actions and decisions;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of Travis County, Texas;
- Notify the Risk and Benefit Manager of any improper use or disclosure of PHI of which it becomes aware;
- Make PHI available to an individual based on HIPAA's access requirements;
- Make PHI available for amendment and incorporate any changes to PHI based on HIPAA's amendment requirements;
- Make available the information required to provide an accounting of disclosures of PHI;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with HIPAA;
- Ensure adequate separation of management between the Plan and Plan Sponsor as required by HIPAA; and

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- If feasible, return or destroy all PHI that Travis County, Texas still maintains in any form and retain no copies of such PHI when no longer needed for the specified disclosure purpose. If return or destruction is not feasible, Travis County, Texas will limit further uses and disclosures to those purposes that make the return or destruction infeasible.

In order to receive ePHI from the Plan, Travis County, Texas agrees that it will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that Travis County, Texas creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that access to, and use and disclosure of ePHI by the employees or classes of employees described in this Plan document is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom Travis County, Texas provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the Risk and Benefit Managerany security incident of which Travis County, Texas becomes aware.

Only the following classes of employees under the control of Travis County, Texas may have access to PHI or ePHI:

- HR/Benefit Analyst. This class also includes those persons responsible for interacting with members, employees, providers, business associates, and others in resolving eligibility, benefits, claims, coordination of benefits, and other plan administration issues.

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- Information Technology Administrators, Operations Support Personnel and Technical Support Personnel. These personnel include personnel responsible for creating and maintaining plan content, information, data sets and applications, and other related information Assets. These personnel may also be responsible for organization web sites, connectivity within the organization's networks, electronic mail, and connectivity with external networks.
- Clerical Personnel. These personnel include mail personnel, secretarial support, and others responsible for document handling and preparation.
- Supervision. Supervisors include only those persons who directly supervise other direct users of PHI.
- Financial Analysts for Health Plan.
- Benefit Administrator. This class also includes those responsible for preparing and submitting information to potential business associates and in managing performance of existing associates.

These employees may only have access to, use and disclose PHI for purposes of the plan administration.

If you believe your rights under HIPAA have been violated, you have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services. Travis County, Texas has provided a mechanism for resolving issues of noncompliance by employees described above who have access to PHI or ePHI. For more information about resolving issues of non-compliance, contract the Risk and Benefit Manager at the Human Resources Management Department, 2nd Floor, 1010 Lavaca Street, Austin, Texas, (512) 854-9499. All other terms, provisions, and conditions shown in your Health Benefits Plan Booklet will continue to apply. All other terms, provisions and conditions shown in this SPD will continue to apply.

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Combined

Summary Plan Description (SPD)

Choice CoInsured Plan for Travis County Employees and Choice CoInsured Plan for Travis County Retirees

Group Number: 701254
Effective Date: October 1, 2009

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Introduction

This Summary Plan Description ("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 Amendments.

We especially encourage you to review the following:

- Benefit limitations in Section 1: What's Covered--Benefits and Section 2: What's Not Covered--Exclusions.
- Section 9: General Legal Provisions.

Many of the sections of the SPD are related to other sections. You may not have all of the information you need by reading just one section. You should call the Claims Administrator if you have questions about the limits of the coverage available to you.

Your Physician does not have a copy of your SPD and is not responsible for knowing or communicating your Benefits.

Note: This SPD is a combined description for multiple plans. The SPD describes the benefits offered in the following plans: Choice CoInsured Plan for Travis County Employees and Choice CoInsured Plan for Travis County Retirees.

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Information about Defined Terms

Certain capitalized words have the special meanings stated in Section 10: Glossary of Defined Terms. Refer to Section 10 for a clearer understanding of your SPD.

"We", "us", and "our" in this document refer to the Plan Sponsor.

"You" and "your" refer to people who are Covered Persons as 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 your contribution.

Customer Service and Claims Submittal

Customer Service Representative (for questions about Coverage or procedures): is shown on your ID card.

Claims Administrator for Prior Notification: is shown on your ID card.

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

Claims Submittal Address:
United HealthCare Insurance Company
Attn: Claims
P.O. Box 30555
Salt Lake City, Utah 84130-0555

Requests for Review of Denied Claims and Notice of Complaints:
United HealthCare Insurance Company
P.O. Box 30432
Salt Lake City, Utah 84130-0432

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Section 1: What's Covered--Benefits

This section provides you with information about:

- Accessing Benefits.
- Copayments, CoInsurance, Eligible Expenses.
- Annual Deductible, Out-of-Pocket Maximum, Maximum Plan Benefit.
- Covered Health Services.
- Covered Health Services that require you or your provider to notify the Claims Administrator before you receive them.

Accessing Benefits

You must see a Network Physician to obtain Network Benefits.

You must show your identification card "ID card" every time you request health care services from a Network provider. If you do not show your ID card, Network providers may bill you for the entire cost of the services you receive. For details about Network Benefits, see Section 3: Obtaining Benefits.

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

- Covered Health Services are received after the Plan is in effect.
- Covered Health Services are received before 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 in the Plan.

Copayment and CoInsurance

Copayment and CoInsurance are the amounts you pay each time you receive certain Covered Health Services.

CoInsurance – the charge you are required to pay for specified Covered Health Services. CoInsurance is calculated as a percentage of Eligible Expenses.

Copayment – the charge you are required to pay for specified Covered Health Services. A Copayment is a set dollar amount.

Copayment and CoInsurance amounts are listed on the following pages next to the description for each Covered Health Service.

Eligible Expenses

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

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

When you receive Covered Health Services from Network providers, you are not responsible for any difference between the

Eligible Expenses and the amount the provider bills. When you receive Covered Health Services from Non-Network providers, you are responsible for paying, directly to the Non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses.

Out-of-Pocket Maximum

Out-of-Pocket Maximum – is the maximum amount you pay for Annual Deductible and CoInsurance every calendar year. Benefits with Copayments will never be payable at 100%.Where applicable, you will always pay a Copayment even after you have met your Out-of-Pocket Maximum.

Once you reach the Out-of-Pocket Maximum for Network Benefits, we will pay Network Benefits for Covered Health Services at 100% CoInsurance for Eligible Expenses during the rest of that calendar year.

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

- Any charges for non-Covered Health Services;
- Copayments for Covered Health Services available under this SPD or any Rider.
- The amount of any Benefits that is reduced if you don't notify the Claims Administrator as described in Section 1: What's Covered--Benefits.
- Charges that exceed Eligible Expenses.

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

- Any charges for non-Covered Health Services.
- Charges that exceed Eligible Expenses.
- The amount of any Benefits that is reduced if you don't notify the Claims Administrator as described in Section 1: What's Covered--Benefits.
- Copayments for Covered Health Services available under this SPD or any Rider.

Copayments for Covered Health Services in Section 1: What's Covered--Benefits do not apply to the Out-of-Pocket Maximum.

Requirement to Notify the Claims Administrator

In general, Network providers are responsible for notifying the Claims Administrator before they provide specified services to you. There are some Network Benefits, however, for which you must notify the Claims Administrator before you receive certain Covered Health Services.

For emergency services, notify the Claims Administrator as soon as possible, but at least one business day before post-Emergency treatment begins.

For Mental Health and Substance Abuse Benefits, you must get authorization in advance of any inpatient treatment through the Mental Health/Substance Abuse Designee by calling the telephone number on the back of your ID card. If you don’t notify the Mental Health/Substance Abuse Designee, we will not pay any Benefits and you will be responsible for paying all charges.

When you receive specified Covered Health Services from Non-Network providers, you must also notify the Claims Administrator before you receive some specified Covered Health Services.

To ensure prompt and accurate payment of your claim as a Network Benefit, notify the Claims Administrator within two business days or as soon as possible after you receive outpatient Emergency Health Services at a Non-Network Hospital or Alternate Facility.

Services for which you must provide prior notification and the minimum notice period appear in the table labeled Benefit Information. See the heading: **Notification Required.**

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

When you choose to receive services from Non-Network providers, confirm with the Claims Administrator that the services you plan to receive are Covered Health Services, even if not indicated in the table labeled Benefit Information under the heading: **Notification Required,** because the circumstances surrounding some procedures may affect whether the procedure is a Covered Health Service and whether it will be excluded. By calling before you receive treatment, you can determine if the service is subject to limitations or exclusions such as:

- The Cosmetic Procedures exclusion. Examples of procedures that may or may not be considered Cosmetic include: breast reduction and reconstruction (except 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.

If you don't notify the Claims Administrator, Benefits will be reduced by $250 for each hospital inpatient stay, each nursing facility stay, each reconstructive procedure, each treatment plan or single item of Durable Medical Equipment or prosthetic device; however, the reduction in Benefits will not exceed Eligible Expenses for the Covered Health Services. This reduction does not help you to meet the Annual Deductible or the Out of Pocket Maximum.

Benefits will not be reduced for the outpatient Emergency Health Services.

If you do not notify the Claims Administrator about Transplant Procedures, you will be responsible for paying all charges and Network Benefits will not be paid. Non-Network Benefits will not be available.

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.

Special Note About Experimental, Investigational or Unproven Service

If you have a Sickness or condition that is likely to cause death within one year of your request for treatment, we and the Claims Administrator may, in our discretion, determine that an Experimental, Investigational or Unproven Service meets the definition of a Covered Health Service for that Sickness or condition if we and the Claims Administrator 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.

Special Note About Medicare

If you are eligible for Medicare please refer to Medicare Eligibility information in Section 9: General Legal Provisions.

Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services in a calendar year before we begin paying Benefits for Covered Health Services to which CoInsurance applies in that calendar year. The actual amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. See Eligible Expenses, in Section 10: Glossary of Defined Terms.	$400 per Covered Person per calendar year, for not more than three Covered Persons in a family.
Out-of-Pocket Maximum	The maximum you pay, out of your pocket, in a calendar year for Annual Deductible and CoInsurance. For a complete discussion of Out-of-Pocket Maximum, see page 3 in this Section 1. The Out-of-Pocket Maximum does include the Annual Deductible.	$1,500 per Covered Person per calendar year, for not more than two Covered Persons in a family.
Maximum Plan Benefit	The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Plan or any other Plan of Plan Sponsor.	$2,000,000 per Covered Person.

Benefit Information

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
1. Acupuncture Services must be provided by a person who specializes in acupuncture and is licensed by the appropriate authority for regulating acupuncture within the jurisdiction in which the services are provided and is operating within the scope of that license. Services must be for one of the following conditions: • Post operative nausea • Nausea due to chemotherapy • Nausea during the first trimester of pregnancy • Treatment of pain Each treatment is limited to three modalities during a visit. Covered Services are limited to a combined total of 30 visits each Calendar Year.	20%	Yes	Yes
2. Ambulance Services - Emergency and Medically Appropriate Only Emergency ambulance services by a licensed ambulance service whether transported or not. Transport is to the nearest Hospital that is medically equipped to perform the needed emergency health services. Ambulance services when required due to a medical condition.	20%	Yes	Yes

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
3. Cancer Resource Services We will arrange for access to certain of our Network providers that participate in the Cancer Resource Services Program for the provision of oncology services. We may refer you to Cancer Resource Services, or you may self refer to Cancer Resource Services by calling 866-936-6002. The oncology services include Covered Health Services and supplies rendered for the treatment of a condition that has a primary or suspected diagnosis relating to cancer. In order to receive Benefits under this program, Cancer Resource Services must provide the proper notification to the Network provider performing the services. This is true even if you self refer to a Network provider participating in the program. When these services are not performed in a Cancer Resource Services facility, Benefits will be paid the same as Benefits for Hospital-Inpatient Stay, Outpatient Surgery, Diagnostic and Therapeutic Services, Physician's Office Services, and Professional Fees for Surgical and Medical Services stated in this Section 1: What's Covered--Benefits.	20% **Notification Required** Cancer Resource Services must be called.	Yes	Yes

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
4. Colonoscopies and other Scopies Diagnostic and therapeutic scopic procedures and related services including laboratory charges received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office. Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy. Surgical scopic procedures, which are for the purpose of performing surgery. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.	0%	No	No

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
5. Dental Services - Accident only Dental services when all of the following are true: • Treatment is necessary because of accidental damage. • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D.". • The dental damage is severe enough that initial contact with a Physician or dentist occurred within 96 hours of the accident. Benefits are available only for treatment of a sound, natural tooth, restored teeth, and prosthesis in good condition to be restored to pre-accident condition. The Physician or dentist must certify to the pre-accident condition of the injured tooth. Dental services for final treatment to repair the damage must be both started within three months of the accident and completed within 12 months of the accident. Oral surgery, full or partial dentures, fixed bridge work, prompt repair to natural teeth, and crowns are covered **only** if needed because of accidental injury and the accident occurred while the Covered Person is covered by this Plan. The least costly, dentally necessary treatment will be considered a Covered Benefit in these circumstances. Dental damage that occurs as a result of normal activities of daily living, such as chewing or eating ice, is not considered an "accident" and repairs to teeth that are injured as a result of such activities are not covered.	20% **Notification Required** Notify the Claims Administrator, and ask for Care Coordination℠, as soon as possible, but at least one business day before post-Emergency treatment begins.	Yes	Yes

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
6. Disposable Medical Supplies Disposable Medical Supplies that meet each of the following criteria: • Ordered or provided by a Physician for outpatient use. • Used for medical purposes to treat a Sickness, Injury or their symptoms. • Not generally useful to a person in the absence of a Sickness, Injury or their symptoms. • Appropriate for use in the home. • Available through a medical supplier and not generally available in grocery or general merchandise stores. Examples of Disposable Medical Supplies include the following: • Two medically appropriate pairs of elastic stockings each year, • Diabetic supplies including the following: — Standard insulin syringes with needles, — Blood testing strips – glucose, — Urine testing strips – glucose, — Ketone testing strips and tablets, — Lancets and lancet devices, — Glucometers (every two years). • Inhaler spacers. • Colostomy bags and supplies. • Intravenous tubing. • Respiratory therapy supplies.	20% ***Diabetic Supplies*** 0%	Yes No	Yes No

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Ace bandages. • Gauze and dressings when used with Durable Medical Equipment.			
7. Durable Medical Equipment Durable Medical Equipment that meets each of the following criteria: • Ordered or provided by a Physician for outpatient use. • Used for medical purposes to treat a Sickness, Injury or their symptoms. • Not generally useful to a person in the absence of Sickness, Injury or their symptoms. • Appropriate for use in the home. • Capable of withstanding repeated use. • Not consumable or disposable. • Available through a medical supplier and not generally available in grocery or general merchandise stores. Examples of Durable Medical Equipment include: • Equipment to assist mobility, such as a standard wheelchair. • A standard Hospital-type bed. • Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).	0% **Notification Required** Pre-Notification required for any Durable Medical Equipment over $1,000 whether for purchase or rental.	No	No

- Delivery pumps for tube feedings (including tubing and connectors).
- Braces that stabilize an Injured body part and braces to treat curvature of the spine. Orthotic devices that straighten or change the shape of a body part such as arm, leg, neck and back braces are covered, including necessary adjustments to shoes to accommodate braces. However, orthotic shoes or shoe inserts unless attached to a brace and dental braces are excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure.

We provide Benefits only for a single purchase (including repair/ replacement) of a type of Durable Medical Equipment once every three calendar years unless an additional purchase is required by a change in your physical condition. If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are only available for the most cost-effective piece of equipment.

We and the Claims Administrator will decide if the equipment should be purchased or rented. To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor the Claims Administrator identifies.

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
8. Emergency Health Services Services that are required to stabilize or initiate treatment provided by or under the direction of a Physician in an Emergency. An **Emergency** is a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which arises suddenly and in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid placing the patient's life or health in serious jeopardy, causing serious impairment to bodily functions, serious dysfunction of any bodily organ or part or in the case of a pregnant woman, serious disfigurement or serious jeopardy to the health of a fetus. Emergency Health Services are always paid as a Network Benefit. If you seek Emergency care at a Non-Network facility, you are not required to meet the Annual Deductible or to pay any difference between Eligible Expenses and the amount the provider bills.	$100 per visit which is waived if an Inpatient Stay is required. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility. **Notification Required** For Non-Network facility, Call the Claims Administrator and ask for Care Coordination℠, on the day of admission or within one business day, or as soon as reasonably possible, but only if an Inpatient Stay is required. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the Non-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Benefits will not be available.	No	No

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
9. Eye Examinations and Vision Therapy Eye examinations received from a health care provider in the provider's office. Network Benefits include one routine vision exam, including refraction, to detect vision impairment by a Network Provider each calendar year. Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses. Vision therapy (Synonyms include: eye exercise therapy, optometric visual (or vision) therapy, vision training, orthoptic training and pleoptic training)	$25	No	No
10. Home Health Care Services received from a Home Health Agency, a program or organization authorized by law to provide health care services in the home, that are both: • Ordered by a Physician. • Provided by or supervised by a registered nurse in your home. Skilled care includes skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true: • Care is 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. • Care is not delivered to assist with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.	0% Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and skilled care is required.	No	No

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Care requires clinical training to be delivered safely and effectively. • It is not Custodial Care. Home Health Care includes temporary or part-time care by a home health aide. 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 is not considered "skilled" simply because there is not an available caregiver.			
11. Hospice Care Hospice care is an integrated program that provides comfort and support services for the terminally ill who are not expected to live more than six months. 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 recommended by a Physician and received from a licensed hospice agency. Contact the Claims Administrator at the telephone number on your ID Card for more information about guidelines for hospice care.	0%	No	No

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
12. Hospital - Inpatient Stay 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 with two or more beds or a private room only if a Semi-private Room is not available or a private room is appropriate in terms of generally accepted medical practice. Benefits for Physician services are described under Professional Fees for Surgical and Medical Services.	$100 per Inpatient Stay, then 20% of Eligible Expenses	No for $100 Yes for 20%	Yes
13. Injections received in a Physician's Office This Benefit is available when only injections are received in a Physician's office and no other health service is received. When other health services are received, Benefits are described under Physician's Office Services below. Allergists are considered as primary care.	***For a Primary Care Provider**** $15 ***For a Non-Primary Care Provider**** $25 *No Copayment applies when there is no Physician charge	No No	No No

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

14. Maternity Services

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

The initial visit to the Network obstetrician who diagnoses pregnancy and is primarily responsible for the Covered Person's maternity care is subject to a Physician's Office Visit Copayment. This Copayment covers all subsequent routine prenatal and post-natal office visits to that Network Physician. All tests after the diagnoses that are recommended by that Network Physician are subject to applicable deductibles and CoInsurance. The Current Procedural Terminology is the guideline for determining whether the procedure is routine or a special service.

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 before the anticipated childbirth.

Copayment and CoInsurance are determined by the type of maternity service and are the same as for other Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.

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

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

We will pay Benefits for an Inpatient Stay of:

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

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

Examples of additional Covered Services related to pregnancy are:

- Birth Center Services including room and board, anesthetics.
- Nurse-Midwife services by a licensed or certified Nurse-Midwife.
- Routine Well Baby care before the mother is released from the hospital including nursery care, circumcision by a surgeon and Physician services when the baby is healthy.

Services for a healthy new born child during the initial hospital stay if the baby leaves the hospital when the mother is released are covered as part of the mother's pregnancy benefits. Services for a new born child during the initial hospital stay when the new born is not healthy or is not able to leave the hospital when the mother is released are covered as benefits for the child, not as the mother's pregnancy benefits.

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
15. Mental Health and Substance Abuse Services - Outpatient Mental Health Services and Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including: • Mental health, substance abuse and chemical dependency evaluations and assessment. • Diagnosis. • Treatment planning. • Referral services. • Medication management. • Short-term individual, family and group therapeutic services (including intensive outpatient therapy). • Crisis intervention. Referrals to a Mental Health/Substance Abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Network Benefits for outpatient Mental Health and Substance Abuse Services. Mental Health Services and/or Substance Abuse Services are limited to a combined total of 60 visits per calendar year.	***For Masters and Ph.D. level Counselors*** $15 per individual visit; ***For Psychiatrists*** $25 per individual visit;	No No	No No

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
16. Mental Health Services - Inpatient and Intermediate Mental Health Services received on an inpatient or intermediate care basis in a Hospital or an Alternate Facility. The Mental Health/Substance Abuse Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. At the discretion of the Mental Health/Substance Abuse Designee, two sessions of intermediate care (such as partial hospitalization) may be substituted for one inpatient day. Network Benefits for Mental Health Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. For Network Benefits, referrals to a Mental Health provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for inpatient/intermediate Mental Health Services.	$100 per Inpatient Stay, then 20% of Eligible Expenses **Notification Required** Mental Health/ Substance Abuse Designee must approve Benefits in advance of any treatment.	No for $100 Yes for 20%	Yes

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
17. Substance Abuse Services - Inpatient and Intermediate Substance Abuse Services received on an inpatient or intermediate care basis in a Hospital or an Alternate Facility. Benefits include detoxification from abusive chemicals or substances that is limited to physical detoxification when appropriate to protect your physical health and well-being. The Mental Health/Substance Abuse Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. At the discretion of the Mental Health/Substance Abuse Designee, two sessions of intermediate care (such as partial hospitalization) may be substituted for one inpatient day. Network Benefits for Substance Abuse Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. For Network Benefits, referrals to a Substance Abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee about Benefits for inpatient/intermediate Substance Abuse Services. Benefits for Substance Abuse Services are limited to two admissions of 30 days during a lifetime.	$100 per Inpatient Stay, then 20% of Eligible Expenses **Notification Required** Mental Health/ Substance Abuse Designee must approve Benefits in advance of any treatment.	No for $100 Yes for 20%	Yes

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
18. Outpatient Surgery ***Outpatient Surgery-Facility*** Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility includes only the facility charge and the charge for required Hospital-based professional services, supplies and equipment. Benefits for the surgeon fees related to outpatient surgery are described under Professional Fees for Surgical and Medical Services. ***Outpatient Surgery-Office*** When these services are performed in a Physician's office, Benefits are described under Physician's Office Services below.	$25 per surgical procedure, then 20% of Eligible Expenses	No for $25 Yes for 20%	Yes
19. Outpatient Diagnostic Services Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including: • Lab. • Radiology/X-ray. • Mammography*. • CT scans, PET scans, MRI, and nuclear medicine. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a Physician's office, Benefits are described under Physician's Office Services below.	20% *The CoInsurance for both Network Diagnostic and Therapeutic Mammography is 0%, the same as if received under Physician's Office Services. The Deductible does not apply for Mammography.	Yes	Yes

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
20. Outpatient Therapeutic Services Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a Physician's office, Benefits are described under Physician's Office Services below.	20% **Notification Required** Notify the Claims Administrator, and ask for Care Coordination℠, at least one day before dialysis begins	Yes	Yes
21. Physician's Office Services **Physicians may be Primary Care or Non-Primary Care. The areas of Primary Care include:** • General Practice • Family Practice • Pediatrics • Internal medicine • Allergy and Immunology • Obstetrics • Gynecology • Chiropractic medicine • Licensed professional counseling (Masters or Ph.D. level) • Licensed clinical social work (Masters or Ph.D. level) • Psychology (Masters or Ph.D. level) **All other providers are Non-Primary Care providers.**	**For a Primary Care Provider*** $15 per visit **For a Non-Primary Care Provider*** $25 per visit *No Copayment applies when there is no Physician charge	No No	No

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

Covered Health Services for the diagnosis and treatment of a Sickness or Injury received in a Physician's office.

Covered Health Services for preventive medical care.
Preventive medical care includes:

- Voluntary family planning including contraceptive drugs, services and devices like:
  - Intrauterine devices and related Physician charges;
  - Physician services related to diaphragm fitting;
  - Voluntary sterilization by either vasectomy or tubal ligation (diaphragm and oral contraceptive costs are covered under Prescription Drug benefits). For exclusions, see Section 2.
- Well-baby and well-child care, including PKU testing.
- One routine physical examination for each Covered Person each calendar year.
- Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment. See Eye Examinations earlier in this section.)
- Immunizations.
- Pre-natal and post natal care.
- One well woman examination each calendar year including:
  - Breast examination and mammogram;
  - Pelvic examination;
  - Pap smear.

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
22. Professional Fees for Surgical and Medical Services Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls. When these services are performed in a Physician's office, Benefits are described under Physician's Office Services above.	20%	Yes	Yes
23. Prosthetic Devices External prosthetic devices that replace a limb or an external body part, limited to: • Artificial arms, legs, feet and hands. • Artificial eyes, ears and noses. • Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm. If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device. The prosthetic device must be ordered or provided by, or under the direction of a Physician. Except for items required by the Women's Health and Cancer Rights Act of 1998, Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every three calendar years unless required by physical change in patient's condition.	0%	No	Yes

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

24. Reconstructive Procedures

Services for reconstructive surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiological function. Changes or improvements in physical appearance as a result of a reconstructive procedure do not classify it as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves the function of a body part. Cosmetic Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiological function are excluded from coverage. Psychological consequences or socially avoidant behavior to a Covered Person as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve the consequences or behavior as a reconstructive procedure.

Benefits for reconstructive surgery include removal of scar tissue on the neck, face, or head if the scar tissue is due to Sickness or accidental Injury, breast reconstruction following a necessary mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women's Health and Cancer Rights Act of 1998, including 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.

Copayment and CoInsurance are determined by the type of service and are the same as for other Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
25. Rehabilitation Services - Outpatient Therapy Short-term outpatient rehabilitation services for: • Physical therapy (limited to three modalities during a visit). • Occupational therapy. • Speech therapy. • Pulmonary rehabilitation therapy. • Cardiac rehabilitation therapy. Rehabilitation services must be performed by a licensed therapy provider in accordance with a written treatment plan, 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. We will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from a defined organic sickness, autism, neurological deficit, congenital anomaly or bodily damage not resulting from physical illness, disease, pregnancy, mental illness, or substance abuse.	$5 per visit for the first 20 visits. After the 20th visit, $15 per visit. ***For services received during an Inpatient hospital stay*** 20%	No Yes	No Yes

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
26. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room with two or more beds or a private room only if a Semi-private Room is not available or a private room is necessary in terms of generally accepted medical practice. 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. Benefits are limited to a combined total of 60 days per calendar year.	$100 per Inpatient Stay *, then 20% of Eligible Expenses *No Copayment applies if you are transferred to a Skilled Nursing Facility or Inpatient Rehabilitation Facility directly from an acute facility.	No for $100 Yes for 20%	Yes
27. Spinal Treatment A Spinal Treatment is using manual or mechanical means to detect or correct subluxation in the body to remove nerve interface or its effects. The interference must result from or relate to distortion, misalignment or subluxation of or in the vertebral column. Benefits for Spinal Treatment when provided by a Spinal Treatment provider in the provider's office. Benefits include diagnosis and related services and are limited to three modalities of treatment per day. Benefits for Spinal Treatment are limited to a combined total of 30 visits per calendar year.	$15 per visit	No	No

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
28. Transplantation Services 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. The search for bone marrow/stem cell from a donor who is not biologically related to the patient is 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. • Cornea transplants that are provided by a Network Physician at a Network Hospital.	20% **Notification Required** Notify the Claims Administrator, and ask for Care Coordination℠, at least seven (7) working days before the evaluation, donor search, organ procurement, and transplant or as soon as the possibility of a transplant arises and before a pre-transplantation evaluation is performed at a transplant center.	Yes	Yes

For cornea transplants, Benefits will be paid at the same level as Professional Fees for Surgical and Medical Services, Outpatient Surgery, Diagnostic and Therapeutic Services, and Hospital - Inpatient Stay rather than as described in this section "Transplantation Services."

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage. Contact the Claims Administrator at the telephone number on your ID card for information about the specific guidelines about Benefits for transplant services.

Transportation and Lodging
For all Covered Transplantation Services

Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows if the transplant recipient resides more than 50 miles from the Facility:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
- Eligible Expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $100 per person, up to $200 for two people.
- If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging and meal expenses are paid at a per diem rate of up to $100 per person, up to $300 for three people.

Description of Covered Health Service	The Amount You Pay CoInsurance is based on a percent of Eligible Expenses	Does Amount You Pay Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
The Claims Administrator will assist the patient and family with travel and lodging arrangements. There is a combined overall lifetime maximum Benefit of $10,000 per Covered Person for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures.			
29. Urgent Care Center Services Covered Health Services received at an 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. 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.	$25 per visit	No	No

Section 2: What's Not Covered--Exclusions

This section contains information about:

- How headings are used in this section.
- Medical services that are not covered.

How We Use Headings in this Section

To help you find specific exclusions more easily, we use 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 the service is recommended or prescribed by a Physician or is the only available treatment for your condition.

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

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

A. Alternative Treatments

1. Acupressure.
2. Aroma therapy.
3. Hypnotism.
4. Massage Therapy.
5. Rolfing.
6. Ecological or environmental medicine, diagnosis or treatment.
7. Herbal medicine, holistic or homeopathic care, including drugs.
8. 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.
7. Membership costs for health clubs, weight loss clinics, and similar programs.
8. Private Duty Nursing Care as an Inpatient.

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

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, except if allowed in Section 1: What's Covered--Benefits under the heading Dental Services - Accident only.
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.(Prescription Drugs are covered under the Attached Rider.)
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.

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

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.

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 under Section 10 Glossary of Defined Terms.

If a Covered Person has a condition which 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 Experimental, Investigational or Unproven Service meets the definition of a Covered Health Service for the condition if the Claims Administrator determines that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

F. Foot Care, Unless Due to Severe Systemic Disease

1. Routine foot care (including the cutting or removal of corns and calluses). Hygienic and preventive maintenance foot care. Examples include the following:
   - Nail trimming, cutting, or debriding.
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

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— Other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.

2. Treatment of flat feet.
3. Treatment of subluxation of the foot.
4. Shoe orthotics unless attached to a brace.

G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Non-prescribed medical supplies and disposable supplies such as more than two medically appropriate stockings each year.

H. Mental Health/Substance Abuse

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.
2. Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention.
3. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis which are not listed in the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.
4. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.
5. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
6. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee.
7. Non-Network Residential treatment services unless multi-disciplinary treatment is required for the diagnosis or use of a network facility is not practicable due to the unusual circumstances of the patient and the diagnosis.
8. Services of a pastoral counselor.
9. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following:
   — Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
   — Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
   — Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
   — Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time.

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

I. Nutrition

1. Megavitamin and nutrition based therapy, chelation therapy, except to treat heavy metal poisoning.
2. Nutritional counseling for either individuals or groups unless due to diabetes or a cardiac condition.
3. Nutritional and electrolyte supplements, including infant formula and donor breast milk and enteral feedings, unless enteral feeding is the only nutrition received.

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.
2. Breast reduction surgery that is determined to be a Cosmetic Procedure.
3. Prophylactic removal of breast, replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure or prophylactic removal of breast implant unless medically appropriate.
   Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed a necessary mastectomy. See Reconstructive Procedures in Section 1: What's Covered--Benefits.
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. Special foods, food supplements, liquid diets, diet plans or any related products are excluded.
6. Wigs or toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness regardless of the reason for the hair loss.

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

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 ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility unless it is a center of excellence, when that Physician or other provider:
   - — Has not been actively involved in your medical care prior to ordering the service, or
   - — Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography testing.

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L. Reproduction Treatment

1. Health services and associated expenses for infertility treatments.
2. Surrogate parenting.
3. The reversal of voluntary sterilization.
4. Procedures which facilitate a pregnancy but do not treat the cause of infertility, such as in vitro fertilization, artificial insemination, embryo transfer, gamete intrafallopian transfer, zygote intrafallopian transfer, and tubal ovum transfer.

   This exclusion does not apply to diagnoses of infertility.

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 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.

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2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan).
3. Health services for transplants involving mechanical or animal organs.
4. Any solid organ transplant that is performed as a treatment for cancer.
5. Any multiple organ transplant not listed as a Covered Health Service under the heading Transplantation 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 hearing aids, eye glasses or contact lenses.
2. Fitting charge for hearing aids, eye glasses or contact lenses.
3. 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.

Note: Treatment of cataracts is a Covered Health Service.

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.

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

2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
   - — Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
   - — Related to judicial or administrative proceedings or orders.
   - — Conducted for purposes of medical research.
   - — Required to obtain or maintain a license of any type.
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, except for Post Traumatic Stress Disorder.
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 except for services provided while in a confinement that began before coverage ended.
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. If a provider waives Copayments, CoInsurance and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, CoInsurance 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. Non-surgical treatment of obesity, including morbid obesity.
11. Surgical treatment of obesity even if morbidly obese with a BMI greater than 35.
12. Growth hormone therapy unless approved by Claims Administrator.
13. Sex transformation operations.
14. Custodial Care which means care that is furnished mainly to train or assist in activities of daily living, instead of providing medical treatment or that can adequately be provided by person who does not have the technical skills of a health care professional.
15. Domiciliary care.
16. Private duty nursing while confined in a facility.
17. Respite care.
18. Rest cures.
19. Psychosurgery.
20. Treatment of benign gynecomastia (abnormal breast enlargement in males).
21. Medical and surgical treatment of excessive sweating (hyperhidrosis).
22. Panniculectomy, abdominoplasty, thighplasty, brachioplasty, mastopexy, and breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reconstruction following a mastectomy as described under Reconstructive Procedures in Section 1: What's Covered--Benefits
23. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

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24. Oral appliances for snoring.
25. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from a defined organic sickness, autism, neurological deficit, congenital anomaly or bodily damage not resulting from physical illness, disease, pregnancy, mental illness, or substance abuse.
26. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
27. Any charge for services, supplies or equipment advertised by the provider as free.
28. Any charges prohibited by federal anti-kickback or self-referral statutes.
29. Services or supplies received before a Covered Person or his or her Dependent becomes covered by this Plan.
30. Education, training, and bed and board while in an institution which is mainly a school, training institution, a place of rest or a place for the aged.
31. Charges made by a Hospital for non-acute care services that may be covered when provided by other appropriate providers for any of the following:
    a. Adult or child day care center.
    b. Ambulatory surgical center.
    c. Birth center.
    d. Half-way house.
    e. Hospice.
    f. Skilled nursing facility.
    g. Treatment center.
    h. Vocational rehabilitation center.
    i. Any other area where services are not for the acute care of sick, injured or pregnant persons.

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32. Telephone consultations.
33. Tobacco dependency.

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Section 3: ObtainingBenefits

This section includes information about:
- Obtaining Benefits.
- Emergency Health Services.

Benefits

Benefits are payable for Covered Health Services which are either of the following:

- Provided by a Network Physician, Network facility, or other Network provider.
- Emergency Health Services.
- Urgent Care Center services received outside the service area.

Benefits are not payable for Covered Health Services that are provided by Non-Network providers.

Mental Health and Substance Abuse Services must be authorized by the Mental Health/Substance Abuse Designee. See Section 1: What's Covered--Benefits under the heading for Mental Health and Substance Abuse.

Provider Network

The Claims Administrator arranges for health care providers to participate in a Network. The network of providers is subject to change. It is your responsibility to select your provider. You may check the Network providers through www.myuhc.com or verify the provider's status by calling the Claims Administrator. Before obtaining services you should always verify the Network status of a provider. A provider's status may change.

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You might not be able to obtain services from a particular Network provider. A particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

A Network provider's agreement may not include all Covered Health Services. Some Network providers contract to provide only specified Covered Health Services. Refer to your provider directory or contact the Claims Administrator for assistance.

Care Coordination[SM]

Your Network Physician must notify the Claims Administrator about certain proposed or scheduled health services. When your Network Physician notifies the Claims Administrator, they will work together to implement the Care Coordination[SM] process and to provide you with information about additional services available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy.

Other Providers

If you have a medical condition that the Claims Administrator believes needs special services, they may direct you to another provider chosen by them. If you require specified complex Covered Health Services for which expertise is limited, the Claims Administrator may direct you to a Non-Network facility or provider.

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In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the provider chosen by the Claims Administrator.

You or your Network Physician must notify the Claims Administrator of special service needs (including, transplants or cancer treatment) that might warrant referral to a Designated Facility or a Non-Network facility or provider. If you do not notify the Claims Administrator in advance, and if you receive services from a Non-Network facility or other Non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Plan.

Health Services from Non-Network Providers Paid as Network Benefits

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

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

Non-Network Benefits Exception

You may be eligible to receive Benefits for certain Non-Network Covered Health Services paid at the Network level if you do not have access to a Network provider within a 30 mile radius of your home zip code.

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You can check a provider's Network status by visiting www.myuhc.com or by calling the Claims Administrator at the toll-free number on your ID card. We and the Claims Administrator must approve any Benefits payable under this exception before you receive care.

Limitations on Selection of Providers

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

If you don't make a selection within 31 days of the date we notify you, the Claims Administrator will select a single Network Physician for you.

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

Non-Network Benefits

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

Limitations on Selection of Providers

If the Claims Administrator determines that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, you may be required to select a single Network

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

Physician to provide and coordinate all future Covered Health Services.

If you don't make a selection within 31 days of the date we notify you, the Claims Administrator will select a single Network Physician for you. If you fail to use the selected Network Physician, Benefits for Covered Health Services will not be paid.

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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.

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

How to Enroll

To enroll, the Eligible Person must complete an enrollment process. The Plan Administrator or its designee will give you notice of the necessary process, along with instructions about enrolling 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 your coverage begins on the day that you are discharged from the Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

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Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Eligible Person	***Plan for Employees*** Eligible Person refers to an Eligible Employee 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, Eligible Employee, and Participant, see Section 10: Glossary of Defined Terms. If both spouses are Eligible Persons, each must enroll as a Participant. Except as described in Section 4: When Coverage Begins, Eligible Persons may not enroll.	We determine who is eligible to enroll under the Plan.
	Plan for Retirees Eligible Person refers to two types of person who meets the eligibility rules: • Eligible Retiree. • Eligible Survivor. When an Eligible Person actually enrolls, we refer to that person as a Participant. For a complete definition of Eligible Person, Eligible Retiree, Eligible Survivor, and Participant, see Section 10: Glossary of Defined Terms. If both spouses are Eligible Persons, each must enroll as a Participant. Except as described in Section 4: When Coverage Begins, Eligible Persons may not enroll.	We determine who is eligible to enroll under the Plan.

Who	Description	Who Determines Eligibility
Dependent	***Plan for Employees*** Dependent refers to five types of person who meets the eligibility rules: • Participant's Spouse • Participant's Children. • Participant's Grandchild. • Domestic Partner. • Domestic Partner's Children if Domestic Partner is covered. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent, Participant's Spouse, Participant's Children, Domestic Partner, Domestic Partner's Children, and Enrolled Dependent, see Section 10: Glossary of Defined Terms. Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan. If both parents of a child are enrolled as a Participant, only one parent may enroll the child as a Dependent. Except as described in Section 4: When Coverage Begins, Dependents may not enroll unless eligible under a qualified change in status.	We determine who qualifies as a Dependent.
	Plan for Retirees Dependent refers to three types of person who meets the eligibility rules: • Participant's Spouse • Participant's Children. • Participant's Grandchild. Dependents must either be continuously enrolled from the date of retirement of the Eligible Retiree or Eligible Survivor or from October 1, 2005, whichever is later. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent, Participant's Spouse, Participant's Children, and Enrolled Dependent, see Section 10: Glossary of Defined Terms. Dependents of an Eligible Person	We determine who qualifies as a Dependent.

Who	Description	Who Determines Eligibility
	may not enroll unless the Eligible Person is also covered under the Plan. If both parents of a Dependent child are enrolled as a Participant, only one parent may enroll the child as a Dependent. Except as described in Section 4: When Coverage Begins, Dependents may not enroll unless eligible under a qualified change in status.	

When to Enroll and When Coverage Begins

When to Enroll	Who Can Enroll	Begin Date
Annual Enrollment Period		
Plan for Employees The Annual Enrollment Period is the 30 day period during which an Eligible Person may select the benefit coverages he or she will receive during the following Plan Year.	Eligible Persons may enroll themselves and their Dependents. Eligible Employees may enroll a Domestic Partner. Eligible Employees may only enroll one adult as a Dependent.	The Plan Sponsor determines the Annual Enrollment Period. Coverage begins on October 1st if the Eligible Person completes the enrollment process within 31 days of the date Annual Enrollment begins.
Plan for Retirees The Annual Enrollment Period is the 30 day period during which an Eligible Person may select the benefit coverages he or she will receive during the following Plan Year. The Eligible Person may select the Choice CoInsured Plan for Travis County Retirees, the Choice Plan for Travis County Retirees or the Coinsured Choice Plan for Travis County Retirees.	Eligible Persons may enroll themselves and, if their Dependents have been continuously enrolled from the date of retirement of the Eligible Retiree or Eligible Survivor or from October 1, 2005, they may enroll their Dependents.	The Plan Sponsor determines the Annual Enrollment Period. Coverage begins on October 1st if the Eligible Person completes the enrollment process within 31 days of the date Annual Enrollment begins.

When to Enroll	Who Can Enroll	Begin Date
Newly Eligible Persons		
Plan for Employees These are newly hired Eligible Employees.	Newly Eligible Persons may enroll themselves and their Dependents. Newly Eligible Employees may enroll a Domestic Partner. Eligible Employees may only enroll one adult as a Dependent.	Coverage for newly Eligible Employees begins on the first day of the month following the completion of a 30 day waiting period if the Eligible Person properly completes the enrollment process within 30 days of the date the newly Eligible Person becomes eligible to enroll.
Plan for Retirees These are newly retired Eligible Retirees and newly Eligible Survivor.	Newly Eligible Persons may enroll themselves and their Dependents if they have been enrolled prior to retirement.	Coverage for newly retired Eligible Retirees and newly Eligible Survivors begins immediately.
Adding New Dependents		
Plan for Employees Other than Annual Enrollment Periods, new Dependents can only be added when the proposed person satisfies all criteria for that type of dependent.	Participants may enroll Dependents when they meet the criteria: • Domestic Partner. Eligible Employees may only enroll one adult as a Dependent.	Coverage begins on the first day of the first month after all criteria are met, if the Eligible Person requests and completes an enrollment process within 30 days of meeting all the criteria.
Plan for Retirees New Dependents cannot enroll after they are newly eligible.		

Special Enrollment Period

Plan for Employees

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

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

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

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal Guardianship.
- Court or Administrative Order.

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

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

(Continues on next page)

Birth or Adoption. Coverage begins on the date of the birth or adoption if the Eligible Person completes the enrollment process within 30 days of the birth or adoption.

Marriage. Coverage begins on the first day of the month after the marriage if the Eligible Person completes the enrollment process within 30 days of the event.

Loss of Other Coverage. Coverage begins on the first day of the month after the loss of coverage event date if the Eligible Person completes the enrollment process within 30 days of the event.

Legal Guardianship. Coverage begins on the first day of the month following a full 30 days if the Eligible Person completes the enrollment process within 30 days of the event.

Court or Administrative Order. Coverage begins on the date noted on the court order.

When to Enroll	Who Can Enroll	Begin Date
	— The employer stopped paying the contributions. — In the case of COBRA continuation coverage, the coverage is exhausted.	

Plan for Retirees

There is no special enrollment for retirees or their dependents.

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 meeting the Annual Deductible and for paying Copayments and CoInsurance to a Network provider at the time of service, or when you receive a bill from the provider.

Filing a Claim for Non-Network Benefits

When you receive Covered Health Services from a Non-Network provider, you must request payment from us through the Claims Administrator.

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

If you don't submit a request for payment of Benefits within 12 months after the date of service Benefits for that health service will be denied unless it was not reasonably possible to file the claim within 12 months and proof is given as soon as possible. (This time limit does not apply if you are legally incapacitated.) If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

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

A. Participant's name and address.
B. The patient's name, age and relationship to the Participant.
C. The member number stated on your ID card.
D. An itemized bill from your provider that includes the following:
   - Patient diagnosis
   - Date of service or supplies incurred
   - Procedure code(s) and description of service(s) rendered
   - Provider of service (Name, Address and Tax Identification Number)
E. The date the Injury or Sickness began.
F. A statement indicating whether you are 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).

Benefit Determinations

Through the Claims Administrator, we will make a benefit determination.

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Urgent Requests for Benefits that Require Immediate Action

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

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

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

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

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

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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 appeal procedures.

Post-Service Claims

Post-Service Claims are claims that are filed 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 you don't provide the needed information within 45-days, your claim will be denied.

If all of the needed information is received within the 45 days and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received.

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

Pre-Service Requests for Benefits

Pre-service requests for Benefits are requests that require notification or approval before receiving medical care. If your pre-service request for Benefits was submitted properly with all needed information, you will receive written notice of the decision from the Claims Administrator within 15 days of receipt of the request. If you did not file a pre-service request for Benefits properly, the Claims Administrator will notify you of how to correct it within 5 days after

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the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, the Claims Administrator will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15 days and pend your request until all information is received. You then have 45 days to provide this information. If you don't provide the needed information within the 45-day period, your claim will be denied. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for Benefits, your request will be decided within 24 hours, provided your request is made at least 24 hours before 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 before the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the urgent request timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

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Benefit Determinations

You may not assign your Benefits under the Plan to a Non-Network provider without our consent. The Claims Administrator may, however, in its discretion, pay a Non-Network provider directly for services rendered to you.

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Section 6: Questions, Complaints 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 have a complaint.
- How to handle an appeal that requires immediate action.
- You are notified that a claim has been denied because it has been determined that a service or supply is excluded under the Plan and you wish to appeal such determination.

What to Do First

If your 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 concern in writing. If you are not satisfied with a benefit determination as described in Section 5: How to File a Claim, you may appeal it without informally contacting Customer Service. If you request a formal appeal, a

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

Customer Service representative will provide you with the appropriate address of the Claims Administrator.

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

The Customer Service telephone number is shown on your ID card.

How to Appeal a Claim Decision

If you disagree with a pre-service request for Benefits determination or post-service claim determination after following the steps in Section 5, you can contact the Claims Administrator in writing to formally 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.

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

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will be conducted and you will be notified by the Plan Sponsor as described in Appeal to Plan Sponsor.

Appeal Process to Claims Administrator

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

Appeals Determinations

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.

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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.

First Level Appeals

Pre-Service Requests for Benefits Appeals

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

For appeals of pre-service requests for Benefits as defined in Section 5: 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 request for Benefits.

Post-Service Requests for Benefits Appeals

For appeals of post-service claims as defined in Section 5: 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.

Second Level Appeals to Plan Sponsor

If you are dissatisfied with the Claims Administrator's decision, you may appeal that decision to the Plan Sponsor. You may not appeal that decision until all appeal procedures available through the Claims Administrator have been exhausted.

You must file your appeal to the Plan Sponsor with its Risk and Benefit Manager at its Human Resources Management Department within 60 days after you receive the first level appeal decision of coverage for Health Services from the Claims Administrator. The appeal must be in writing and must include at least the following information and authorizations:

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- Your name and social security number
- The name of the person whose care is being appealed
- The name and address of the medical providers involved
- A clear statement of the level of service requested and the amount of indemnity request
- A detailed explanation of the reason that the appeal should be considered
- Copies of all documents previously submitted for consideration to the Claims Administrator for its review of its decision not to approve coverage for Health Services
- An authorization for release of medical information to the Risk and Benefit Manager, the Appeals Committee panel hearing the appeal, and the County Attorney advising the panel, and
- An authorization for review and discussion of medical information to the Risk and Benefit Manager, the Appeals Committee panel hearing the appeal, and the County Attorney advising the panel as necessary to hear and determine the appeal.

The appeal should be enclosed in a sealed envelope or a sealed box and marked "Confidential Appeal" to notify the Plan Sponsor that the contents should be kept confidential. If the appeal is marked "Confidential Appeal", it will only be opened by the Risk and Benefit Manager or the Director of the Human Resources Management Department.

Within five businesses days after receipt of an appeal, the Risk and Benefit Manager will establish an Appeal Committee panel of three members from the Appeals Committee appointed by the Commissioners Court. This panel will include at least one licensed medical practitioner with expertise that is appropriate to the medical issue being appealed and the Risk and Benefit Manager or his representative. The Risk and Benefit Manager will set the time,

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location, and agenda for the Appeals Committee hearing and post Open Meetings notices.

The panel will review the information you submitted and hold a hearing to make a decision about the appeal. A representative of the County Attorney may also attend the appeal hearing but cannot vote on the appeal.

The Appeals Committee panel must issue a written decision with reasons for its decision within 7 business days after the Risk and Benefit Manager receives the complete written appeal. Written decisions of a panel of the Appeal Committee will not include any information that identifies who you are, like your name or social security number. This 7 business days does not begin until you have provided all of the required information.

Meetings of an Appeals Committee panel must comply with the Texas Open Meetings Act. Notice of meetings must be posted and the panel may go into closed session to discuss the appeal.

You may present information to the Appeals Committee panel at the hearing in both open and closed session. If you present the information in writing, you can preserve the confidentiality of your identity. If you choose to present information orally in person in open session at the hearing of the panel, the fact that you presented the information in this manner acts as a release of the medical information presented to everyone at the open session of the hearing and a waiver of any right you would otherwise have to confidentiality of your identity.

You will be allowed to be present in the closed session unless the panel needs to receive legal advice about the appeal. You will not be allowed to be present for any legal advice that is provided in closed session.

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All written information you provide in the appeal, all oral information you provide in closed session at the hearings, and all discussions about any appeal by the Appeal Committee panel must be kept confidential.

The Plan Sponsor must notify you of the second level appeal decision within 30 days after receiving the second level appeal from you.

The Plan Sponsor has the exclusive right to interpret and administer the Plan. The decision of the Appeals Committee panel is final. There is no further appeal of this decision.

The Plan Sponsor'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.

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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. 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 determine which Coverage Plan will pay as the Primary Coverage Plan. The Primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some expenses. A Secondary Coverage Plan pays after the Primary Coverage Plan and may reduce the benefits it pays. This is to prevent payments from all group Coverage Plans from exceeding 100 percent of the total Allowable Expense.

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NOTE: This Coordination of Benefits provision does not apply to Prescription Drug Products covered through this Plan.

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, or no-fault, benefits under group or individual automobile contracts; medical benefits coverage under homeowner's insurance; 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.

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

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

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

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

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

4. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.
5. "Closed Panel Plan" is a Coverage Plan that provides health benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
6. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with

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

Order of Benefit Determination Rules

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

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

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

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

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

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

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

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

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

1) The parents are married;

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

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

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

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

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

1) The Coverage Plan of the custodial parent;

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

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

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 the Coverage Plans meeting the definition of Coverage Plan

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

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

Effect on the Benefits of this Plan

A. When this Coverage Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Coverage Plans during a claim determination period are not more than 100 percent of total Allowable Expenses. As each claim is submitted, this Coverage Plan will determine its obligation to pay or provide benefits under its contract.

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

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

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

1. 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.

2. 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

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are determined as if the services were covered under Medicare Parts A and B.

3. 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.

4. 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.

5. The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

Right to Receive and Release Needed Information

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

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

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we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied but will be reprocessed when the needed information is provided.

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 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).

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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 after 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
Entire Plan Ends	Your coverage ends on the date the Plan ends. We are responsible for notifying you that your coverage has ended.
You Are No Longer Eligible	Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Participant or Enrolled Dependent. See Section 10: Glossary of Defined Terms for a more complete definition of the terms "Eligible Person", "Eligible Employee", "Eligible Retiree", "Eligible Survivor", "Participant", "Dependent" and "Enrolled Dependent".
Claims Administrator Receives Notice to End Coverage	Your coverage ends on the last day of the calendar month in which the Claims Administrator receives written notice from us instructing the Claims Administrator to end your coverage, or the date requested in the notice, if later.
Participant Retires	Your coverage as an Eligible Employee ends the last day of the calendar month in which the Participant is retired if you do not enroll as an Eligible Retiree under the Plan. We are responsible for providing written notice to the Claims Administrator to end your coverage. This provision applies for retired persons, only if the Participant continues to meet any applicable eligibility requirements and makes the required premium payments.

Other Events Ending Your Coverage

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

Ending Event	What Happens
Fraud, Misrepresentation or False Information	Fraud or misrepresentation, or because the Participant knowingly gave us or the Claims Administrator false material information. Examples include false information relating to another person's eligibility or status as a Dependent. We have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.
Material Violation	There was a material violation of the terms of the Plan.
Improper Use of ID Card	You permitted an unauthorized person to use your ID card, or you used another person's card.
Failure to Pay	You failed to pay a required contribution.
Threatening Behavior	You committed acts of physical or verbal abuse that pose a threat to our staff, the Claims Administrator's staff, a provider, or other Covered Persons.

Coverage for a Handicapped Child

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:

- Enrolled Dependent child is not able to be self-supporting because of mental retardation or physical handicap.
- Enrolled Dependent child 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 Claims 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 Claims Administrator agrees to this extension of coverage for the child, the Claims Administrator may require that a Physician chosen by us examine the child. We will pay for that examination.

The Claims Administrator may continue to ask you for proof that the child continues to meet these conditions of incapacity and dependency. This 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 Claims Administrator's request as described above, coverage for that child will end.

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

Continuation Coverage under Federal Consolidated Omnibus Budget Reconciliation Act ("COBRA")

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 Spouse who is an Enrolled Dependent.
- A Participant's Child who is an Enrolled Dependent, including a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law.
- A Participant's former legal spouse, at the time of separation or divorce.

A Domestic Partner and a Domestic Partner's Child are not Qualified Beneficiaries.

Qualifying Events for Continuation Coverage under 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.

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

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

With respect to a Participant's Spouse or Participant's Child who is a Qualified Beneficiary, the qualifying events are:

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

Notification Requirements and Election Period for Continuation Coverage under COBRA

Notification Requirements for Qualifying Event

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

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

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

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

Notification Requirements for Disability Determination or Change in Disability Status

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

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

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

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

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

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

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Participant will lose these special COBRA rights. COBRA

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

coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period

Terminating Events for Continuation Coverage under 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 events A and B).

   If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at any time within the first 60 days of continuation coverage for qualifying event A or B, then the Qualified Beneficiary may elect an additional eleven months of continuation coverage (for a total of twenty-nine months of continued coverage) subject to the following conditions:

   6. Notice of such disability must be provided within the latest of 60 days after:
      a. the determination of the disability; or
      b. the date of the qualifying event; or
      c. the date the Qualified Beneficiary would lose coverage under the Plan; and
      d. in no event later than the end of the first eighteen months.
   7. The Qualified Beneficiary must agree to pay any increase in the required premium for the additional eleven months.

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8. If the Qualified Beneficiary who is entitled to the eleven months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional eleven months of continuation coverage.

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

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

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

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

2. Thirty-six months from the date of the Participant's Medicare entitlement, if a second qualifying event (that was due to either the Participant's termination of employment or the Participant's work hours being reduced) occurs prior to the expiration of the eighteen months.

D. For Qualified Beneficiaries, and to the extent that the Participant became entitled to Medicare subsequent to the qualifying event:

1. Thirty-six months from the date of the Participant's termination from employment or work hours being reduced (first qualifying event) if:

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

a. The Participant's Medicare entitlement occurs within the eighteen month continuation period; and
b. Absent the first qualifying event, the Medicare entitlement would have resulted in a loss of coverage for the Qualified Beneficiary under the group health plan.

E. The date coverage terminates under the Plan for failure to make timely payment of the premium.

F. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

G. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event G). If the Qualified Beneficiary was entitled to continuation because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event G) and the retired Participant dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for thirty-six months from the date of the Participant's death.

H. The date the entire Plan ends.

I. The date coverage would otherwise terminate under the Plan as described in this section under the heading Events Ending Your Coverage.

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

Section 9: General Legal Provisions

This section provides you with information about:
- General legal provisions concerning the Plan.

Plan Document

This SPD is part of the official plan documentation and represents an overview of your medical and pharmacy Benefits. The Claims Administrator administers for medical and pharmacy benefits in accordance with the SPD. The official plan documentation includes information not found in the medical SPD such as other employee benefits that may be available to you (e.g., dental, FSA, life, disability etc.) and associated benefit communications including insurance policies, certificates, booklets, benefit brochures, employee web site information, and enrollment guides. In the event there is a discrepancy between the SPD and the official plan documentation, the plan documentation governs. A copy of the plan documentation is available upon written request from the Plan Administrator. You (or your personal representative) may obtain a copy of this documentation, for a nominal charge, by written request to the Plan Administrator.

Our 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.

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

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. We do not have any other relationship with Network providers such as principal-agent or joint venture. Neither we nor the Claims Administrator are liable for any act or omission of any provider.

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

We are solely responsible for all of the following:

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

Your Relationship with Providers

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

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

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

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

Incentives to Providers

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

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

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

Rebates and Other Payments

We and the Claims Administrator may receive rebates for specified drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. We and the Claims Administrator do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copayments and CoInsurance.

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 specified 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.

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

Administrative Services

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

Amendments to the Plan

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 federal statutes or regulations, or applicable state law provisions not otherwise preempted by the Public Health Service Act 42 U.S.C. 300bb-3 (of the jurisdiction in which the Plan is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

Any change or amendment to or termination of the Plan, its benefits or its terms and conditions, in whole or in part, shall be made solely in a written amendment to the Plan (in the case of a change or amendment) or in a written resolution (in the case of a termination), whether prospective or retroactive, 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.

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

Clerical Error

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

Information and Records

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

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

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

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the information gathered under the Plan for research and analytic purposes.

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

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

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

Examination of Covered Persons

If a question or dispute about your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

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

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.

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

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you **should** enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, we will assume the position of a secondary payer as described in Section 7: Coordination of Benefits, and 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 and Reimbursement

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

Right to Subrogation

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

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

Right to Reimbursement

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

Third Parties

The following persons and entities are considered third parties:

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

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Subrogation and Reimbursement Provisions

As a Covered Person, you agree to the following:

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- The Plan may enforce its subrogation and reimbursement rights regardless of whether you have been "made whole" (fully compensated for your injuries and damages).
- You will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - Complying with the terms of this section.
  - Providing any relevant information requested.
  - Signing and/or delivering documents at its request.
  - Appearing at medical examinations and legal proceedings, such as depositions or hearings.
  - 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

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alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.

- If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- You will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a Sickness or Injury caused by a third party.
- The Plan's rights will not be reduced due to your own negligence.
- The Plan may file suit in your name and take appropriate action to assert its rights under this section. The Plan is not required to pay you part of any recovery it may obtain from a third party, even if it files suit in your name.
- The provisions of this section apply to the parents, guardian, or other representative of an Enrolled Dependent child who incurs a Sickness or Injury caused by a third party.
- In case of your wrongful death, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs.
- 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.

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Refund of Overpayments

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

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

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

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

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 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 and that provides one or more of the following services on an outpatient basis, as permitted by law:

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

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

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

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.

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Cancer Resource Services Program - the program made available by the Plan Sponsor to Participants. The Cancer Resource Services Program provides information to Participants or their Enrolled Dependents with cancer and offers access to additional cancer centers for the treatment of cancer.

Child - an unmarried dependent child of the Participant or Participant's spouse, under 26 years of age who is primarily dependent upon the Eligible Employee for support and maintenance and who is not regularly employed on a full time basis for 20 hours or more per week. The term child includes any of the following:

- A natural child.
- A stepchild
- A grandchild who resides in the Participant's home and for whom a validly executed and notarized guardianship document has been submitted to Human Resources Management Division.
- A legally adopted child.
- A child placed for adoption.

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

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

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

Claims Administrator - the company (including its affiliates) that provides specified 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 after birth.

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

A Covered Health Service is a health care service or supply or equipment 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 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 and the services do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

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Dependent - the Participant's Spouse or a Participant's Child or Participant's Domestic Partner or Domestic Partner's Child if the Domestic Partner is covered.

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

Dependents must live in the United States.

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.

Domestic Partner - a person who meets all of the following conditions:

- Not employed by the Eligible Employee.
- Not be related to the Eligible Employee by marriage.
- Not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- Share the same residence and the common necessities of life with the Eligible Employee for at least six months before applying for coverage and currently living with the Eligible Employee.
- Have a relationship with the Eligible Employee that includes shared expenses and shared responsibilities for the maintenance and operation of their shared residence

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- Have provided Plan Sponsor with an Affidavit of Domestic Partnership that includes the names of any child for whom coverage is sought.
- Not in active service in the armed forces.
- At least 18 years of age.

A Domestic Partner is not dependent for the purpose of determining a qualified beneficiary as defined in COBRA. Domestic Partners are not eligible for COBRA continuation.

Domestic Partner's Child - a Child of Eligible Employee's Domestic Partner who has been living with the Eligible Employee for at least six months before applying for coverage and is currently living with the Eligible Employee if the Domestic Partner is covered. The term Domestic Partner's Child also includes a child for whom legal guardianship has been awarded to the Participant's Domestic Partner.

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

A Domestic Partner's Child is not dependent for the purpose of determining a qualified beneficiary as defined in COBRA. A Domestic Partner's Child is not eligible for COBRA continuation.

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

Eligible Expenses are based on either of the following:

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

Eligible Person -

Plan for Travis County Employees - an Eligible Employee.

Eligible Persons must live in the United States.

Plan for Travis County Retirees - an Eligible Retiree, or an Eligible Survivor.

Eligible Persons must live in the United States.

Eligible Employee - a current regular full-time employee of the Plan Sponsor who is scheduled to work at his or her job at least 20 hours per week.

Eligible Retiree - a person who meets all of the following conditions:

- terminated or retired from Plan Sponsor
- receiving annuity benefits from the Texas District and County Retirement Association due to employment with Plan Sponsor
- either:
  - continuously covered by a Plan for Retirees or a former Plan for Retirees since termination or retirement, or
  - covered as a retiree on October 1, 2005 and continuously covered by a Plan for Retirees or a former Plan for Retirees since then.

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Eligible Survivor - either of the following:

- A surviving spouse of any person who was receiving annuity benefits from the Texas District and County Retirement Association due to employment with Plan Sponsor if the surviving spouse was covered by the Plan or the former Plan of the Plan Sponsor at the time of the retired person's death and has maintained continuous coverage since the date of the retired person's death, or
- A person who qualifies as an eligible survivor under Subchapter D, Chapter 615 of TEX. GOV'T CODE ANN.

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

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

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

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

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- 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.
- Is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations.
- Is approved by Medicare as a Hospital.
- Is operated continuously with organized facilities for operative surgery on the premises.

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.

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

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

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

Medicare - Parts A, B, C and D 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.

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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 Mental Disorders* published by the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

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

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of Mental Disorders* published by 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 (either directly or indirectly) with the Claims Administrator or with the Claims Administrator's affiliate to participate in the Claims Administrator's Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with them through common ownership or control with the Claims Administrator or with its ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only specified Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of the Claims Administrator's products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the

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participation agreement, and a Non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

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.

Participant's Child - a Child of the Participant or the Participant's Spouse. The term Participant's Child also includes a child for whom legal guardianship has been awarded to the Participant or the Participant's Spouse.

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

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

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

Plan - Choice CoInsured for Travis County Employee Health Benefit Fund Plan.

Plan Administrator - is Travis County or its designee.

Plan Sponsor - Travis County. References to "we", "us", and "our" throughout the SPD refer to the Plan Sponsor.

Pregnancy - includes all of the following:

- Prenatal care.

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

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

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

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

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

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

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)

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- 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.)

Working Day - any business day for County and does not include Saturday, Sunday or County holidays.

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Riders, Amendments, Notices

Outpatient Prescription Drug Rider

Attachment I

Attachment II

Choice CoInsured

Outpatient Prescription Drug Rider

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Outpatient Prescription Drug Rider

This Rider to the SPD provides Benefits for outpatient Prescription Drug Products. Benefits are provided for outpatient Prescription Drug Products at a Network Pharmacy. Certain capitalized words have special meanings. We have defined these words in Section 10: Glossary of Defined Terms of the SPD and in Section 3: Glossary of Defined Terms of this Rider.

"We," "us," and "our" in this document refer to Plan Sponsor. "You" and "your" refer to people who are Covered Persons as the term is defined in the SPD Section 10: Glossary of Defined Terms.

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

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Introduction

Benefits for Outpatient Prescription Drug Products

Benefits are available for Outpatient Prescription Drug Products at a Network Pharmacy and are subject to Copayments. There is no coverage for Prescription Drugs dispensed at a Non-Network Pharmacy.

Identification Card (ID Card) - Network Pharmacy

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

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment and any deductible that applies.

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Designated Pharmacies

If you require certain Prescription Drug Products, the Claims Administrator may direct you to a Designated Pharmacy with whom we have an exclusive arrangement to provide those Prescription Drug Products.

In this case, Benefits will only be paid if your Prescription Order or Refill is obtained from the Designated Pharmacy.

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Rebates and Other Payments

We and the Claims Administrator may receive rebates for certain drugs included on the Prescription Drug List. We or the Claims Administrator do not pass these rebates on to you, nor are they taken into account in determining your Copayments.

The Claims Administrator, and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this Outpatient Prescription Drug Rider. Such business may include data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Outpatient Prescription Drug Rider. The Claims Administrator is

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not required to pass on to you, and does not pass on to you, such amounts.

Coupons, Incentives and Other Communications

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

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

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

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

Benefits for Outpatient Prescription Drug Products

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

When a Brand-name Drug Becomes Available as a Generic

When a Generic becomes available for a Brand-name Prescription Drug Product, your Copayment may change. You will pay the Copayment applicable for a Brand-name Prescription Drug with a Generic Prescription Drug available.

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Supply Limits

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

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

Notification Requirements

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

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

Network Pharmacy Notification

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

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

If the Claims Administrator is not notified before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy.

Pharmacy Benefit Claims

If you are asked to pay the full cost of a prescription when you fill it at a Network Retail or mail-order pharmacy and you believe that the Plan should have paid for it, you may submit a claim for reimbursement as a post-service group health plan claim. If you pay a Copayment and you believe that the amount of the Copayment was incorrect, you also may submit a claim for reimbursement as a post-service group health plan claim.

If a Network Retail or mail order pharmacy fails to fill a prescription that you have presented, you may contact the Claims Administrator by submitting a claim for coverage as a pre-service health plan claim.

You may seek information regarding claims in Section 5: How to File a Claim, and information on appeals in the SPD Section 6 Questions, Complaints and Appeals.

When you submit a claim on this basis, you may pay more because you did not notify the Claims Administrator before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost (for Prescription Drug Products from a Network Pharmacy), less the required Copayment and any deductible that applies.

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

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Specialty Prescription Drug Products

If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an exclusive arrangement to provide those Prescription Drug Products. In this case, benefits will only be paid if your prescription order or refill is obtained from the Designated Pharmacy.

What You Must Pay

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

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

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

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Payment Information

Payment Term	Description	Amounts
Copayment	Copayments for a Prescription Drug Product at a Network Pharmacy are a specific dollar amount. Your Copayment is determined by the type of Prescription Drug Product. Copayments for compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are determined by the category that applies to the main active ingredient in the drug.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment or • The Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug Product. For Prescription Drug Products from a home delivery Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment or • The Prescription Drug Cost for that Prescription Drug Product. ***See the Copayments stated in the Benefit Information table for amounts.*** Drugs which are prescribed, dispensed, or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility are not subject to a Copayment.

Description of Pharmacy Type and Supply Limits	Your Copayment Amount
Prescription Drugs from a Retail Network Pharmacy Benefits are provided for outpatient Prescription Drug Products dispensed by a retail Network Pharmacy. The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Copayment for each cycle supplied. If your physician orders or approves filling your Prescription Drug Order so that you must split the tablets provided to get the appropriate dosage, your Copayment is **half** of the Copayment for the type of Prescription Drug Product prescribed that is shown in the adjacent column.	\$10.00 per Prescription Order or Refill for a **Generic Prescription Drug Product**. \$25.00 per Prescription Order or Refill for a **Brand-Name Prescription Drug Product** when a generic equivalent is not available. \$45.00 per Prescription Order or Refill for a **Brand-Name Prescription Drug Product** when a generic equivalent is available and when provided to a Covered Person who is not a retiree or retiree's dependent **and Specialty Prescription Drug Products** when purchased from a Designated Pharmacy regardless of retiree status. \$35.00 per Prescription Order or Refill for a **Brand-Name Prescription Drug Product** when a generic equivalent is available and when provided to an Eligible Retiree Participant or that retiree's dependent.

Prescription Drug Products from a Home Delivery Network Pharmacy

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

- As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a home delivery Copayment for any Prescription Orders or Refills sent to the home delivery pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or refill for a 90-day supply, not a 30-day supply with three refills.

If your Prescription Drug Order is written so that you must split the tablets provided to get the appropriate dosage, your Copayment is **half** of the Copayment for the type of Prescription Drug Product prescribed that is shown in the adjacent column.

For up to a 90-day supply, your Copayment is:

$20.00 per Prescription Order or Refill for a **Generic Prescription Drug Product**.

$50.00 per Prescription Order or Refill for a **Brand-Name Prescription Drug Product** when no generic equivalent is available.

$90.00 per Prescription Order or Refill for a **Brand-Name Prescription Drug Product** when a generic equivalent is available and when provided to a Covered Person who is not a retiree or retiree's dependent **and Specialty Prescription Drug Products** when purchased from a Designated Pharmacy regardless of retiree status.

$70.00 per Prescription Order or Refill for a **Brand-Name Prescription Drug Product** when a generic equivalent is available and when provided to an Eligible Retiree Participant or that retiree's dependent.

Section 2: What's Not Covered--Exclusions

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

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

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17. Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill.
18. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug. Prescription Drug Products that are comprised of components that are available in over-the-counter form or equivalent.
19. New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by the Claims Administrator's Prescription Drug List Management Committee.
20. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

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Section 3: Glossary of Defined Terms

This section:

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

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

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

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

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

Network Pharmacy - a pharmacy that has:

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

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

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

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

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

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

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - Standard insulin syringes with needles;
  - Blood-testing strips - glucose;
  - Urine-testing strips - glucose;
  - Ketone-testing strips and tablets;
  - Lancets and lancet devices;
  - Glucose monitors.

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

Specialty Prescription Drug Product **-** Prescription Drug Products that are identified by Plan Administrator as a Specialty Drug, which are generally high cost, biotechnology or genetically-engineered drugs used to treat patients with certain illnesses.

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

- End of Outpatient Prescription Drug Rider -

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Attachment I

Women's Health and Cancer Rights Act of 1998

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

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

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

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

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

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

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Attachment II

Travis County Employee Health Benefit Fund Plan Document

The Use and Disclosure of Protected Health Information and Security of Electronic Protected Health Information

Under the federal privacy regulations enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your health plans are required to protect the confidentiality of your Protected Health Information. Protected Health Information (PHI) is individually identifiable health information related to your condition, services provided to you, or payments made for your care, which is created or received by a health plan, a health care clearinghouse, or a health care provider that electronically transmits such information. Travis County Employee Health Benefit Fund and Travis County, Texas will not use or disclose health information protected by HIPAA, except for treatment, payment, health plan operations (collectively known as "TPO"), as permitted or required by other state and federal law, or to business associates to help administer the Plan.

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All disclosures of the PHI by a health insurance issuer or HMO to the Plan Sponsor will comply with the restrictions and requirements set forth in the Plan and in the "504" provisions.

The Plan may not, and may not permit a health insurance issuer or HMO, to disclose members' PHI to the Plan Sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of

- Obtaining premium bids from health plans for providing health insurance coverage under the Plan, or
- Modifying, amending, or terminating the Plan.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the "504" provisions.

Further, Travis County, Texas will take reasonable steps to ensure that any use or disclosure is the minimum necessary to accomplish the task.

In addition, under the federal security regulations enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your health plans are required to safeguard the confidentiality and ensure the integrity and availability of your Electronic Protected Health Information. Electronic Protected Health Information (ePHI) is PHI that is maintained or transmitted in electronic form. Travis County Employee Health Benefit Fund and Travis County, Texas will reasonably and appropriately

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

safeguard ePHI created, received, maintained, or transmitted to or by Travis County, Texas on behalf of the Plan.

The Plan and Travis County, Texas exchange information to coordinate your Plan coverage. Travis County, Texas agrees to and has certified that it will:

- Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;
- Ensure that any agents, including subcontractors, to whom it provides PHI received from Travis County Employee Health Benefit Fund agree to the same restrictions and conditions that apply to Travis County, Texas with respect to such information;
- Not use or disclose PHI for employment-related actions and decisions;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of Travis County, Texas;
- Notify the Risk and Benefit Manager of any improper use or disclosure of PHI of which it becomes aware;
- Make PHI available to an individual based on HIPAA's access requirements;
- Make PHI available for amendment and incorporate any changes to PHI based on HIPAA's amendment requirements;
- Make available the information required to provide an accounting of disclosures of PHI;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with HIPAA;
- Ensure adequate separation of management between the Plan and Plan Sponsor as required by HIPAA; and

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- If feasible, return or destroy all PHI that Travis County, Texas still maintains in any form and retain no copies of such PHI when no longer needed for the specified disclosure purpose. If return or destruction is not feasible, Travis County, Texas will limit further uses and disclosures to those purposes that make the return or destruction infeasible.

In order to receive ePHI from the Plan, Travis County, Texas agrees that it will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that Travis County, Texas creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that access to, and use and disclosure of ePHI by the employees or classes of employees described in this Plan document is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom Travis County, Texas provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the the Risk and Benefit Manager any security incident of which Travis County, Texas becomes aware.

Only the following classes of employees under the control of Travis County, Texas may have access to PHI or ePHI:

- HR/Benefit Analyst. This class also includes those persons responsible for interacting with members, employees, providers, business associates, and others in resolving eligibility, benefits, claims, coordination of benefits, and other plan administration issues.

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- Information Technology Administrators, Operations Support Personnel and Technical Support Personnel. These personnel include personnel responsible for creating and maintaining plan content, information, data sets and applications, and other related information Assets. These personnel may also be responsible for organization web sites, connectivity within the organization's networks, electronic mail, and connectivity with external networks.

- Clerical Personnel. These personnel include mail personnel, secretarial support, and others responsible for document handling and preparation.

- Supervision. Supervisors include only those persons who directly supervise other direct users of PHI.

- Financial Analysts for Health Plan.

- Benefit Administrator. This class also includes those responsible for preparing and submitting information to potential business associates and in managing performance of existing associates.

These employees may only have access to, use and disclose PHI for purposes of the plan administration.

If you believe your rights under HIPAA have been violated, you have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services. Travis County, Texas has provided a mechanism for resolving issues of noncompliance by employees described above who have access to PHI or ePHI. For more information about resolving issues of non-compliance, contract the Risk and Benefit Manager at the Human Resources Management Department, 2nd Floor, 1010 Lavaca street, Austin, Texas, (512) 854-9499. All other terms, provisions, and

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

conditions shown in your Health Benefits Plan Booklet will continue to apply. All other terms, provisions and conditions shown in this SPD will continue to apply.

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

Summary Plan Description

Choice Plus Plan for Retirees,

Choice Plus Plan for Employees,

EPO Choice Plan for Employees,

EPO Choice Plan for Retirees

Coinsured Choice Plan for Employees

Coinsured Choice Plan for Retirees, the Travis County Health Benefit Plan

Effective: October 1, 2010
Group Number: 701254

UnitedHealthcare®
A UnitedHealth Group Company

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SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance Use Disorder Administrator: 1-866-649-4873;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 30555, Salt Lake City, Utah 84130-0555; and
- Online assistance: **www.myuhc.com**.

Travis County is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members. It includes summaries of:

- who is eligible;
- what you have to contribute to costs of services that are covered,
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

This SPD is designed to meet your information needs. It supersedes any previous printed or electronic SPD for this Plan.

Note: This SPD is a combined description for multiple plans. The SPD describes the benefits offered in the following plans: Choice Plus Plan for Employees, Choice Plus Plan for Retirees, Choice Plan for Employees, Choice Plan for Retirees, CoInsured Plan for Employees and CoInsured Plan for Retirees. Please read this SPD thoroughly to learn how the Travis County Health Benefit Plans work. Please reference the sections that pertain to the Benefits in the Plan that you have chosen. If you have questions contact your local Human Resources Management Department or call the number on the back of your ID card.

Travis County intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice.

This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps Travis County to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. Travis County is solely responsible for paying Benefits described in this SPD.

How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can obtain copies of your SPD and any future amendments by contacting the Human Resources Management Department.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Member as defined in Section 14, *Glossary*.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plans;
- The factors that impact your cost for coverage;
- Instructions and timeframes for enrolling yourself and your eligible dependents;
- When coverage begins; and
- When you can make coverage changes under the Plans.

Eligibility

Plans for Employees

You are eligible to enroll in the Plan if you are a regular employee who is scheduled to work at least 20 hours per week. To be eligible for coverage under the Plan, a Member must reside within the United States.

Your eligible dependents may also participate in the Plan.

Plans for Retirees

You are eligible to enroll in the Plan if you are a person who:

- is terminated or retired from Travis County
- is receiving annuity benefits from the Texas County and District Retirement Association due to employment with Travis County, and
- either
  - retires while covered under one of the Employee Plans and maintains coverage continuously under one of the Retiree Plans after retirement or
  - has been covered under one of the Retiree Plans continuously since October 1, 2005.

To be eligible for coverage under the Plan, a Member must reside within the United States.

Your eligible dependents may also participate in the Plan if you were covering them on an Employee Plan just before your retired and continued coverage for them under one of the Retiree Plans when You retired and have maintained coverage continuously for them after Your retirement or You have covered them continuously as Your dependents while You were a retiree since October 1, 2005.

Dependents

An eligible dependent is considered to be:

- your Spouse, Sponsored Dependent, or Domestic Partner as defined in Section 14, Glossary;

- your child who is under age 26, including:
  - a natural child,
  - a stepchild,
  - a legally adopted child in the Member's home,
  - a child placed in the Member's home for adoption,
  - a child for whom you are the legal guardian,
  - a grandchild for whom you are the legal guardian,
  - any other child related to the Member who is mainly dependent on the Member for care and support and who is residing in the Member's home and for whom a completed guardianship document has been obtained,
  - an unmarried child age 26 or over who is or becomes disabled and is dependent upon you if the child complies with the continuation requirements in Section 12, *When Coverage Ends*, or
  - a child for whom you are required to provide health care coverage through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*;

- your Spouse's child who is under age 26, including:
  - a natural child,
  - a stepchild who resides in the Member's home,
  - a legally adopted child in the Member's home,
  - a child placed in the Member's home for adoption,
  - a child for whom your Spouse is the legal guardian,
  - a grandchild for whom your Spouse is the legal guardian,
  - any other child related to your Spouse who is mainly dependent on the Member for care and support and who is residing in the Member's home and for whom a completed guardianship document has been obtained,
  - an unmarried child age 26 or over who is or becomes disabled and is dependent upon you if the child complies with the continuation requirements in Section 12, *When Coverage Ends*, or
  - a child for whom your Spouse is required to provide health care coverage through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*; and

- your Domestic Partner's child who is under age 26, including:
  - a natural child,
  - a stepchild who resides in the Member's home,
  - a legally adopted child in the Member's home,
  - a child placed in the Member's home for adoption,
  - a child for whom your Domestic Partner is the legal guardian,
  - a grandchild for whom your Domestic Partner is the legal guardian,
  - any other child related to the Domestic Partner who is mainly dependent on the Member for care and support and who is residing in the Member's home and for whom a completed guardianship document has been obtained,

- an unmarried child age 26 or over who is or becomes disabled and is dependent upon you if the child complies with the continuation requirements in Section 12, *When Coverage Ends*, or
- a child for whom your Domestic Partner is required to provide health care coverage through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*.

To be eligible for coverage under the Plan, a dependent must reside within the United States.

Note: Your dependents may not enroll in the Plan unless you are also enrolled. Anyone eligible as an employee or retiree may not enroll as a dependent. In addition, if you and your Spouse or Domestic Partner are both covered under the Travis County Employee Health Benefit Plan, only one parent may enroll your child as a dependent. No one can be a dependent of more than one Member.

Cost of Coverage

Plans for Employees

You and Travis County share in the cost of the Plan. Your contribution is the amount set by the Commissioners Court each year. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks. You may select to have them deducted on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld - and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you. If you select to have your contributions deducted on a before tax basis, you can only change your coverage at Open Enrollment unless a change in family status occurs.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children eligible dependents for income tax purposes. Therefore, the value of Travis County's cost in covering a Domestic Partner may be imputed to the Member as income. In addition, the share of the Member's contribution that covers a Domestic Partner and the Domestic Partner's children must be paid using after-tax payroll deductions.

Your contributions are subject to review and Travis County reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling the Human Resources Management Department.

Plans for Retirees

If You were employed by Travis County for eight years or more before You retired, You and Travis County may share in the cost of the Plan if the Commissioners Court approves a county contribution to the actuarially determined contribution for the applicable plan year. If no county contribution is approved, You must pay the entire actuarially determined

contribution. Your contribution is the amount set by the Commissioners Court each year. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

If You have not been an employee of Travis County for eight years before You retire, You must pay the entire actuarially determined contribution and Travis County will not share in the cost of the Plan. Your contribution is the amount set by the Commissioners Court each year. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

You are invoiced for your contributions and must pay them directly to the invoicing service.

Your contributions are subject to review and Travis County reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling the Human Resources Management Department.

How to Enroll

Plans for Employees

To enroll, call the Human Resources Management Department within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next Open Enrollment to make your Benefit elections.

Each year during Open Enrollment, you have the opportunity to review and change your medical Plan election. Any changes you make during Open Enrollment will become effective the following October 1.

Important
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact the Human Resources Management Department within 31 days of the event. Otherwise, you will need to wait until the next Open Enrollment to change your elections.

Plans for Retirees

To enroll, call the Human Resources Management Department within 30 days before the date you plan to retire. If You do not enroll before the date you retire, You will not be able to enroll later.

If You are covered when You retire and continuously maintain Your coverage or were retired and have continuously maintained Your coverage since October 1, 2005, each year during Annual Enrollment, You have the opportunity to enroll to continue coverage under a Retiree medical Plan for Yourself and any dependents for whom You have continuously maintained coverage since Your retirement or, if retired on October 1, 2005, You have continuously maintained their coverage since October 1, 2005. In addition, You may select this coverage from the Choice Plus Plan for Retirees, the EPO Choice Plan for Retirees or the Coinsured Choice Plan for Retirees. You may also elect to discontinue this coverage for

Yourself or Your dependents for the rest of Your life or their lives. Any changes You make during Annual Enrollment will become effective the following October 1.

When Coverage Begins

Plans for Employees

Once the Human Resources Management Department receives your properly completed enrollment, coverage will begin on the first day of the month after the end of a 30 day waiting period. Coverage for your dependents will start on the date your coverage begins, if you have enrolled them in a timely manner.

Coverage for a Spouse or dependent stepchild that you acquire through marriage becomes effective the first of the month after the date the Human Resources Management Department receives notice of your marriage, if you notify the Human Resources Management Department within 31 days after your marriage.

Coverage for dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, if you notify the Human Resources Management Department within 31 days after the birth, adoption, or placement.

Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Plans for Retirees

Once the Human Resources Management Department receives your properly completed enrollment, coverage will begin on the first day of your retirement. Coverage for your dependents will start on the date your coverage begins, if you have enrolled them in a timely manner.

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, the Plan will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify UnitedHealthcare within 48 hours of the day your coverage begins, or as soon as is reasonably possible.

Changing Your Coverage

Plans for Employees

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you can cover your Spouse following your marriage, your child following an adoption, but not your

Spouse following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- your acquisition of a Domestic Partner;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- a loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a dependent;
- your dependent child no longer qualifying as an eligible dependent;
- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage;
- a significant or material change in the contributions or Plan design of the employee or Covered Dependent coverage;
- you or your eligible dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible dependent;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible dependent;
- termination of your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact the Human Resources Management Department within 60 days of termination);
- you or your dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact the Human Resources Management Department within 60 days of determination of subsidy eligibility);
- a strike or lockout involving you or your Spouse; or
- a court or administrative order.

Unless otherwise noted in the list above, if you wish to change your Benefit elections, you must contact the Human Resources Management Department within 31 days of the change in family status. Otherwise, you must wait until the next Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible dependent if COBRA is elected.

Change in Family Status - Example

Jane is married and has two children who qualify as dependents. At Open Enrollment, she elects not to participate in Travis County's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under Travis County's medical plan outside of Open Enrollment if she contacts Human Resources Management Department within 31 days of Tom's last day of medical coverage.

Plans for Retirees

Retirees may not make changes in their coverage during the year. If a Retiree fails to pay the applicable monthly contribution for the coverage elected, after the grace period and notice of failure to pay, their coverage will be terminated. If your coverage is terminated, you will not be eligible to enroll at any subsequent Annual Enrollment.

SECTION 3A - HOW THE CHOICE PLUS PLAN WORKS

What this section includes:

- Network and Non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Coinsurance; and
- Out-of-Pocket Maximum.

Network and Non-Network Benefits

As a Member in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and whether any benefit limitations may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Network Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services. When you receive Covered Health Services at a Network facility, you are eligible for the Network level of Benefits when Covered Health Services are provided under the primary direction of a Network Physician or other provider. Some services at a Network facility may be provided by Non-Network providers because these providers are associated with the Network facility. These services might include Physician services provided by a Non-Network anesthesiologist, Emergency room Physician, consulting Physician on the initial visit, pathologist or radiologist. Services by these providers are covered at the Network level because the primary direction is provided by a Network Physician and services are provided at a Network facility.

Emergency Room Health Services received at a Non-Network Hospital are covered at the Network level.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a Non-Network provider.

If you choose to seek care outside the Network, your cost for the services will generally be higher than if you had gone to a Network provider. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the Non-Network provider about their billed charges before you receive care.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. Network providers are independent practitioners and are not employees of Travis County or UnitedHealthcare.

At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto **www.myuhc.com**.

Looking for a Network Provider?
Use **www.myuhc.com** to search for Physicians available in your Plan.

In addition to other helpful information, **www.myuhc.com**, UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network.

While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information.

Possible Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to coordinate all of your future Covered Health Services. If you do not make a selection within 31 days after the date you are notified, UnitedHealthcare will select a Network Physician for you. If you do not use that Network Physician to coordinate all of your care, any Covered Health Services you receive will be paid at the Non-Network level.

Eligible Expenses

Eligible Expenses are charges for Covered Health Services that are provided while the Plan is in effect, determined according to the definition for Eligible Expenses for Choice Plus Plan in Section 14, *Glossary*.

For certain Covered Health Services, the Plan will not pay the expenses until you have met your Annual Deductible. UnitedHealthcare has the initial discretion to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and covered under the Plan.

For certain Covered Health Services, you are required to pay a percentage of Eligible Expenses in the form of a Copay and/or Coinsurance. Eligible Expenses are subject to UnitedHealthcare's reimbursement policy guidelines. You may request a copy of the guidelines related to your claim from UnitedHealthcare.

Don't Forget Your ID Card
Remember to show your UnitedHealthcare ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits to which the Annual Deductible applies. There are separate Network and Non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate during the calendar year. The Annual Deductible is shown in the first table in Section 5, *Plan Highlights*.

When your Benefit is limited to a specific number of visits or days, any visits or days you pay for as part of your Annual Deductible reduce the number of visits or days available to you in the remainder of the year.

Medical expenses are incurred on the date that you receive the Covered Health Service. If you incur medical expenses in the last three months of any given calendar year and these medical expenses are applied to your Deductible for that year, these medical expenses will also be applied to your Deductible in the next year.

If you are covering dependents, your family deductible is determined individually for the group. Medical expenses incurred for a member of your family will be credited to that individual. If a member of your family incurs medical expenses that are credited to your Deductible in the last three months of any given calendar year, those are applied to the medical expenses you incur in the next year. When those combined expenses equal the individual deductible, your deductible for that member of your family is met. If three members of your family have met their individual Deductible, based on either medical expenses incurred in the last three months of any given calendar year or in the next year, your family deductible is met, even if one or more other family members have not met their individual Deductible in that year.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is usually a set dollar amount and is paid at the time of service or when billed by the provider. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Copays do not count toward the Out-of-Pocket-Maximum.

Copays do not count toward the Annual Deductible.

Coinsurance

Coinsurance is the amount that you are responsible for paying and is calculated as the percentage of Eligible Expenses. After the Annual Deductible is met, Coinsurance is a fixed percentage that applies to certain Covered Health Services.

Coinsurance – Examples

If you receive Plan Benefits for outpatient surgery from a Network provider and you have not met any of your Annual Deductible, you pay the amount of your individual Annual Deductible, then the Plan pays 90% of the rest of the cost of the surgery, and you are responsible for paying the other 10% of the rest of the cost of the surgery. This 10% is your Coinsurance.

If you receive Plan Benefits for outpatient surgery from a Network provider and you have already met your Annual Deductible, the Plan pays 90%, and you are responsible for paying the other 10%. This 10% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you are required to pay each calendar year for Covered Health Services. There are separate Network and Non-Network Out-of-Pocket Maximums for this Plan. If your eligible Out-of-Pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year unless a Copay applies to the service.

Medical expenses are incurred on the date that you receive the Covered Health Service. If you incur medical expenses in the last three months of any given calendar year, and these medical expenses are applied to the Out-of-Pocket Maximum for that year, these medical expenses will also be applied to the Out-of-Pocket Maximum for the next year.

If you are covering dependents, your family Out-of-Pocket is determined both individually and as a group. Medical expenses incurred for a member of your family are credited to both that individual and the family. If medical expenses are incurred for any member of your family, either in the last three months of any given calendar year or in the next year, and these medical expenses equal the family Out-of Pocket maximum, your family Out-of Pocket maximum is met for the current year, even if no single member of your family has incurred medical expenses sufficient to meet an individual Out-of Pocket maximum.

The following table identifies what does and does not apply toward your Network and Non-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Copays	No	No
Charges for Health Services that are not covered	No	No
The amounts of any reductions in Benefits you incur by not notifying Personal Health Support	No	No
Charges that exceed Eligible Expenses	No	No

How the Plan Works - Example

The following example illustrates how Annual Deductibles, Copays, Out-of-Pocket Maximums and Coinsurance work in practice.

Let's say Gary has individual coverage under the Plan. He has met his Network Annual Deductible, but not his Non-Network Annual Deductible and needs to see a Physician. The flow chart below shows what happens when he visits a Network Physician versus a Non-Network Physician.

Network Benefits
1. Gary goes to see a Network Physician, and presents his ID card.
2. He receives treatment from the Physician. The Plan's Eligible Expense for the Network office visit equals $125.
3. On his way out, Gary pays a $25 Copay. Since Network Physician office visits are covered at 100% after the Copay, Gary has met his financial obligations for this office visit.
4. The Plan pays $100 ($125 Eligible Expense minus $25 Copay).

Non-Network Benefits
1. Gary goes to see a Non-Network Physician, and presents his ID card.
2. He receives treatment from the Physician. The Eligible Expense for his visit is $175, however the Physician's fee is $225.
3. The Physician's office requests no payment, informing Gary that it will bill UnitedHealthcare directly.*
4. Gary is responsible for paying the Eligible Expense of $175 directly to the Physician, because he has not yet met his Annual Deductible.
5. Gary receives a bill from the Physician, and pays the Physician directly.

Network Benefits	Non-Network Benefits
	6. The Physician's office, at its discretion, might bill Gary for the remaining $50:

$225	-	$175	=	$50
(Physician's fee)		(Eligible Expense)		

Non-Network Benefits
Gary's $50 payment does not apply to his Annual Deductible or Out-of-Pocket Maximum.
7. UnitedHealthcare applies the $175 toward Gary's Annual Deductible and Out-of-Pocket Maximum.

*Although Non-Network providers have the right to request payment in full at the time of service, they bill UnitedHealthcare directly in most cases.

SECTION 3B - HOW THE CHOICE PLAN AND COINSURED PLAN WORK

What this section includes:

- Network and Non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Coinsurance ; and
- Out-of-Pocket Maximum.

Network and Non-Network Benefits

As a Member in these Plans, you have the freedom to choose the Network Physician or health care professional you prefer each time you need to receive Covered Health Services.

You are eligible for Benefits under these Plans when you receive Covered Health Services from Network Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services. Except as specifically described within the SPD for the Choice Plan and CoInsured Plan, benefits are not available for services provided by a non-Network provider. When you receive Covered Health Services at a Network facility, you are eligible for Benefits when Covered Health Services are provided under the primary direction of a Network Physician or other provider. Some services at a Network facility may be provided by Non-Network providers because these providers are associated with the Network facility. These services might include Physician services provided by a Non-Network anesthesiologist, Emergency room Physician, consulting Physician on the initial visit, pathologist or radiologist. Services by these providers are covered at the Network level because the primary direction is provided by a Network Physician and services are provided at a Network facility.

Members in the Choice Plan or the CoInsured Plan - Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits from a non-Network provider. In this situation, your Network Physician will notify Personal Health Support, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

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

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. Network providers are independent practitioners and are not employees of Travis County or UnitedHealthcare.

At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto **www.myuhc.com**.

Looking for a Network Provider?
Use **www.myuhc.com** to search for Physicians available in your Plan.

In addition to other helpful information, **www.myuhc.com,** UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network.

While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information.

Possible Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a Network Physician for you. In the event that you do not use the Network Physician to coordinate all of your care, any Covered Health Services you receive will not be paid.

Eligible Expenses

Eligible Expenses are charges for Covered Health Services that are provided while the Plan is in effect, determined according to the definition for Eligible Expenses for the Choice and CoInsured Plans in Section 14, *Glossary*.

For certain Covered Health Services, the Plan will not pay these expenses until you have met your Annual Deductible. UnitedHealthcare has the initial discretion to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and covered under the Plan.

For certain Covered Health Services, you are required to pay a percentage of Eligible Expenses in the form of a Copay and/or Coinsurance. Eligible Expenses are subject to UnitedHealthcare's reimbursement policy guidelines. You may request a copy of the guidelines related to your claim from UnitedHealthcare.

Don't Forget Your ID Card
Remember to show your UnitedHealthcare ID card every time you receive health care services from a Network provider. If you do not show your ID card, a Network provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services Expenses before you are eligible to begin receiving Benefits to which the Annual Deductible applies. The amounts you pay toward your Annual Deductible accumulate during the calendar year. The Annual Deductible is shown in the first table in Section 5, *Plan Highlights*.

When a Benefit is subject to a visit or day limit, the balance of the total visits allowed will be reduced by the number of days or visits you use regardless of the Annual Deductible being met or not. Benefits with amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited Benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

Medical expenses are incurred on the date that you receive the Covered Health Service. If you incur medical expenses in the last three months of any given calendar year and these medical expenses are applied to your Deductible for that year, these medical expenses will also be applied to your Deductible in the next year.

If you are covering dependents, your family deductible is determined individually for the group. Medical expenses incurred for a member of your family will be credited to that individual. If a member of your family incurs medical expenses that are credited to your Deductible in the last three months of any given calendar year, those are applied to the medical expenses you incur in the next year. When those combined expenses equal the individual deductible, your deductible for that member of your family is met. If three members of your family have met their individual Deductible, based on either medical expenses incurred in the last three months of any given calendar year or in the next year, your family deductible is met, even if one or more other family members have not met their individual Deductible in that year.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is usually a set dollar amount and is paid at the time of service or when billed by the provider. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Copays do not count toward the Out-of-Pocket-Maximum.

Copays do not count toward the Annual Deductible.

Coinsurance

Coinsurance is the amount that you are responsible for paying and is calculated as the percentage of Eligible Expenses. After the Annual Deductible is met, Coinsurance is a fixed percentage that applies to certain Covered Health Services.

Coinsurance – Examples for the Choice Plan

If you are enrolled in the Choice Plan the coinsurance for all benefits is currently zero percent. If you receive Plan Benefits for outpatient surgery from a Network provider and you have not met any of your Annual Deductible, you pay the amount of your individual Annual Deductible, then the Plan pays 100% of the rest of the cost of the surgery, you are responsible for paying the other 0% of the rest of the cost of the surgery. This 0% is your Coinsurance.

If you receive Plan Benefits for outpatient surgery from a Network provider and you have already met your Annual Deductible, the Plan pays 100%, and you are responsible for paying the other 0%. This 0% is your Coinsurance.

Coinsurance – Examples for the CoInsured Plan

If you are enrolled in the CoInsured Plan and you receive Plan Benefits for outpatient surgery from a Network provider and you have not met any of your Annual Deductible, you pay the amount of your individual Annual Deductible, then the Plan pays 80% of the rest of the cost of the surgery, you are responsible for paying the other 20% of the rest of the cost of the surgery. This 20% is your Coinsurance.

If you receive Plan Benefits for outpatient surgery from a Network provider and you have already met your Annual Deductible, the Plan pays 80%, and you are responsible for paying the other 20%. This 20% is your Coinsurance.

Out-of-Pocket Maximum – Choice Plan

There is no Annual Out-of-Pocket Maximum on the Choice Plan.

Out-of-Pocket Maximum – CoInsured Plan

The annual Out-of-Pocket Maximum is the most you are required to pay each calendar year for Covered Health Services. If your eligible Out-of-Pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year unless a Copay applies to the service.

Medical expenses are incurred on the date that you receive the Covered Health Service. If you incur medical expenses in the last three months of any given calendar year, and these medical expenses are applied to the Out-of-Pocket Maximum for that year, these medical expenses will also be applied to the Out-of-Pocket Maximum for the next year.

If you are covering dependents, your family Out-of-Pocket is determined both individually and as a group. Medical expenses incurred for a member of your family are credited to both that individual and the family. If medical expenses are incurred for any member of your family, either in the last three months of any given calendar year or in the next year, and these medical expenses equal the family Out-of Pocket maximum, your family Out-of Pocket maximum is met for the current year, even if no single member of your family has incurred medical expenses sufficient to meet an individual Out-of Pocket maximum.

The following table identifies what does and does not apply toward your Out-of-Pocket Maximum:

Plan Features	Applies to the Out-of-Pocket Maximum?
Payments toward the Annual Deductible	Yes
Coinsurance Payments	Yes
Copays	No
Charges for Health Services that are not covered	No
The amounts of any reductions in Benefits you incur by not notifying Personal Health Support	No
Charges that exceed Eligible Expenses	No

How these Plans Work - Example

The following example illustrates how Annual Deductibles, Copays, Out-of-Pocket Maximums and Coinsurance work in practice.

Let's say Gary has individual coverage under the Plan. He has met his Network Annual Deductible and needs to see a Physician. The flow chart below shows what happens when he visits a Network Physician.

Choice Plan Benefits	CoInsured Plan Benefits
1. Gary goes to see a Network Physician, and presents his ID card.	1. Gary goes to see a Network Physician, and presents his ID card.
|	|
2. He receives treatment from the Physician. The Eligible Expense for the Network office visit equals $130.	2. He receives treatment from the Physician. The Eligible Expense for the Network office visit equals $130.
|	|
3. On his way out, Gary pays a $30 Copay. Since Network Physician office visits are covered at 100% after the Copay, Gary has met his financial obligations for this office visit.	3. On his way out, Gary pays a $20 Copay. Since Network Physician office visits are covered at 100% after the Copay, Gary has met his financial obligations for this office visit.
|	|
4. The Plan pays $100 ($130 Eligible Expense minus $30 Copay).	4. The Plan pays $110 ($130 Eligible Expense minus $20 Copay).

SECTION 4 - PERSONAL HEALTH SUPPORT

What this section includes:
- An overview of the Personal Health Support program; and
- Covered Health Services for which you need to contact Personal Health Support.

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and Cost-Effective services available. A Personal Health Support Nurse is notified when you or your provider calls the toll-free number on your ID card about an upcoming treatment or service.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with a telephone number so you can call with questions about your conditions, or your overall health and well-being. Personal Health Support Nurses provide a variety of different services to help you and your covered Dependents receive appropriate medical care. Program components and notification requirements are subject to change without notice. As of the publication of this SPD, the Personal Health Support program includes:

- **Risk Management** - Designed for Members with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Members may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the Member's specific chronic or complex condition.
- **Admission counseling** - For upcoming inpatient Hospital admissions for certain conditions, a Treatment Decision Support nurse may call you to help answer your questions and to make sure you have the information and support you need for a successful recovery.
- **Inpatient care management** - If you are hospitalized, your Physician will work with a Treatment Decision Support nurse to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Discharge Management and Readmission Avoidance** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will

also share important health care information, answer questions about, repeat, and reinforce discharge instructions, to support a safe transition home for you.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the toll-free number on your ID card.

Requirements for Notifying Personal Health Support

If you are enrolled in the Choice Plus Plan:

Network providers are generally responsible for notifying Personal Health Support before they provide certain services to you. However, there are some Network Benefits for which you are responsible for notifying Personal Health Support.

When you choose to receive certain Covered Health Services from Non-Network providers, you are responsible for notifying Personal Health Support before you receive these Covered Health Services. In many cases, your Non-Network Benefits will be reduced if Personal Health Support is not notified.

The medical services that require Personal Health Support notification are:

- non-emergency air and ground ambulance;
- Congenital Heart Disease services;
- Emergency Room Health Services if you are admitted to a non-Network Hospital;
- dental services - accident only;
- Durable Medical Equipment for items that will cost more than $1,000 to purchase or rent, including equipment for the management and treatment of diabetes;
- home health care;
- hospice care - inpatient;
- Hospital Inpatient Stay, including Emergency admission;
- spinal treatment as described under *Spinal Treatment* in Section 6, *Additional Coverage Details*;
- maternity care that exceeds the delivery timeframes as described in Section 6*, Additional Coverage Details*;
- outpatient dialysis treatments as described in under *Therapeutic Treatments - Outpatient* in Section 6, *Additional Coverage Details*;
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy;
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services; and
- transplantation services.

For notification timeframes, and reductions in Benefits that apply if you do not notify Personal Health Support, see Section 6, *Additional Coverage Details*.

If you are enrolled in the Choice Plan or Coinsured Plan:

In most cases, Network providers are responsible for notifying Personal Health Support before they provide these services to you. However, you are responsible for notifying the Personal Health Support staff prior to receiving a service for:

- dental services - accident only;
- Emergency Room Health Services if you are admitted to a non-Network Hospital;
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy; and
- transplantation services.

For notification timeframes see Section 6, *Additional Coverage Details*. For timeframes and any reductions in Benefits if you do not notify the Mental Health/Substance Use Disorder Administrator, see Section 6, *Additional Coverage Details*.

Contacting Personal Health Support is easy.
Simply call the toll-free number on your ID card.

Special Note About Mental Health and Substance Use Disorder Services

Pre-service notification is required as described below.

Network Benefits (Provider is responsible for notification)

You are not required to provide pre-service notification when you seek these services from Network providers. Network providers are responsible for notifying the Mental Health/Substance Use Disorder Administrator before they provide these services to you.

Non-Network Benefits (Covered Person is responsible for notification)

If you are enrolled in the Choice Plus Plan - When you seek these services from non-Network providers for a scheduled admission, you must notify the Mental Health/Substance Use Disorder Administrator before 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 subject to a $250 penalty.

The following Benefits require notification.

- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility);
- Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders - inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility);

- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility).

If these Benefits are provided by a Network provider, the provider must notify the Mental Health/Substance Use Disorder Administrator. If these Benefits are provided by a Non-Network provider, you must notify the Mental Health/Substance Use Disorder Administrator

Special Note About Medicare

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to notify Personal Health Support before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 10, *Coordination of Benefits (COB)*.

SECTION 5 - PLAN HIGHLIGHTS

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum. See section 6 for a description of the services included as part of the Covered Health Services, limitations on services, and notification requirements that apply to each Covered Health Service.

If you are enrolled in the Choice Plus Plan, a Copay does not apply when you visit a Non-Network provider except for Emergency Room Health Services.

	CHOICE PLUS		EPO CHOICE	COINSURED CHOICE
Plan Features	**Network**	**Non-Network**	**Network**	**Network**
Copays[1]				
■ Emergency Room Health Services	$125	$125	$125	$125
■ Physician's Office Services - Primary Care Provider	$25	Copay is not applicable, Coinsurance and Deductible apply	$30	$20
■ Physician's Office Services - Specialist	$40	Copay is not applicable, Coinsurance and Deductible apply	$45	$35
■ Rehabilitation Services - Outpatient Therapy	$5 per visit for the first 20 visits after 20 visits a $25 Primary Copay or a $40 Specialist Copay per visit	Copay is not applicable, Coinsurance and Deductible apply	$5 per visit for the first 20 visits; after 20 visits a $30 Primary Copay or a $45 Specialist Copay per visit	$5 per visit for the first 20 visits; after 20 visits a $20 Primary Copay or a $35 Specialist Copay per visit
■ Urgent Care Center Services	$25	Copay is not applicable, Coinsurance and Deductible apply	$25	$25

Plan Features	CHOICE PLUS Network	CHOICE PLUS Non-Network	EPO CHOICE Network	COINSURED CHOICE Network
■ Hospital – Inpatient Stay	$200	$250	$200	$200
■ Skilled Nursing Facility/ Inpatient Rehabilitation Facility Services	$200	$250	$200	$200
Annual Deductible[1]				
■ Individual	$300	$900	$100	$500
■ Family	Total is not to exceed $300 per person for a total of three Covered Persons in a family	$900 per Individual	$300	$1,500
Annual Out-of-Pocket Maximum[1]				
■ Individual	$2,000	$2,500	$1,000	$2,000
■ Family	Not to exceed $2,000 per Covered Person or a total of two Covered Persons in a family	$7,500	Not Applicable	$4,000

Plan Features	CHOICE PLUS Network	CHOICE PLUS Non-Network	EPO CHOICE Network	COINSURED CHOICE Network
Lifetime Maximum Benefit[2] 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.	Unlimited		Unlimited	Unlimited

[1]Copays do not count toward the Annual Deductible or the Out-of-Pocket Maximum. The Annual Deductible counts toward the Out-of-Pocket Maximum for all Covered Health Services.

[2]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.

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*. You must notify Personal Health Support, as described in Section 4, *Personal Health Support* to receive full Benefits before receiving certain Covered Health Services from a Non-Network provider. In general, if you visit a Network provider, that provider is responsible for notifying Personal Health Support before you receive certain Covered Health Services. See Section 6, *Additional Coverage Details* for further information.

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	**Non-Network**	**Network**	**Network**
Acupuncture Services (Copay is per visit) Up to 3 modalities per visit. Up to 30 visits per calendar year	100% after you pay a $25 Primary Copay or $40 Specialist Copay	70% after you meet the Annual Deductible	100% after you pay a $30 Primary Copay or $45 Specialist Copay	100% after you pay a $20 Primary Copay or $35 Specialist Copay
Ambulance Services ■ Emergency Ambulance	90% after you meet the Annual Deductible	90% after you meet the Annual Deductible	100% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Colonoscopies and other Scopies	100%	70% after you meet the Annual Deductible	100%	100%
■ Scopic Procedures - Facility	100%	70% after you meet the Annual Deductible	100%	100%
■ Scopic Procedures - Physician's Fees for Scopies	100%	70% after you meet the Annual Deductible	100%	100%

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	**Non-Network**	**Network**	**Network**
■ Scopic Procedures - Outpatient Preventive See also Diagnostic and Therapeutic Procedures – Outpatient	100%	70% after you meet the Annual Deductible	100%	100%
Congenital Heart Disease (CHD) Surgeries	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Dental Services - Accident Only	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Diagnostic Procedures - Outpatient **Note**: Scopies are covered at 100%				
■ Diagnostic and Therapeutic Mammography testing	100%	70% after you meet the Annual Deductible	100%	100%
■ Diagnostic Outpatient – Facility	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100% after you meet the Annual Deductible	80% after you meet the Annual Deductible
■ Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	Non-Network	Network	Network
Disposable Medical Supplies ■ Disposable Medical Supplies	100%	70% after you meet the Annual Deductible	100%	100%
■ Diabetes Self-Management Items Benefits are also available under Section 15, Prescription Drugs.	100%	70% after you meet the Annual Deductible	100%	100%
Durable Medical Equipment (DME)	100%	70% after you meet the Annual Deductible	100%	100%
Emergency Room Health Services - Outpatient	100% after you pay $125 per visit unless you are admitted as an inpatient to a Network Hospital within 24 hours of receiving Emergency treatment for the same condition			
Eye Examinations and Vision Therapy See Section 6, *Additional Coverage Details*, for limits.	100% after you pay a $25 Primary Copay or $40 Specialist Copay	70% after you meet the Annual Deductible	100% after you pay a $30 Primary Copay or $45 Specialist Copay	100% after you pay a $20 Primary Copay or $35 Specialist Copay
Home Health Care	100%	70% after you meet the Annual Deductible	100%	100%

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	Non-Network	Network	Network
Hospice Care	100%	70% after you meet the Annual Deductible	100%	100%
Hospital - Inpatient Stay	90% after you meet the Annual Deductible and pay $200 per Inpatient Stay	70% after you meet the Annual Deductible and pay $250 per Inpatient Stay	100% after you meet the Annual Deductible and pay $200 per Inpatient Stay	80% after you meet the Annual Deductible and pay $200 per Inpatient Stay
Allergy Injections received in a Physician's Office Allergy serum injections are covered under the Physician's Office Services section when billed in addition to any other service.	No Copay, deductible or coinsurance applies for any allergy serum injection when an office visit charge is not assessed	70% after you meet the Annual Deductible	No Copay, deductible or coinsurance applies for any allergy serum injection when an office visit charge is not assessed	No Copay, deductible or coinsurance applies for any allergy serum injection when an office visit charge is not assessed
Injections received in a Physician's Office ■ Primary Care Provider (Copay is per visit)	100% after you pay a $25 Copay	70% after you meet the Annual Deductible	100% after you pay a $30 Copay	100% after you pay a $20 Copay

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	**Non-Network**	**Network**	**Network**
■ Specialist Physician (Copay is per visit)	100% after you pay a $40 Copay	70% after you meet the Annual Deductible	100% after you pay a $45 Copay	100% after you pay a $35 Copay
Mental Health Services				
■ Hospital - Inpatient Stay	90% after you meet the Annual Deductible and pay $200 per Inpatient Stay	70% after you meet the Annual Deductible and pay $250 per Inpatient Stay	100% after you meet the Annual Deductible and pay $200 per Inpatient Stay	80% after you meet the Annual Deductible and pay $200 per Inpatient Stay
■ Physician's Office Services (Copay is per visit)	100% after you pay a $25 Primary Copay or $40 Specialist Copay	70% after you meet the Annual Deductible	100% after you pay a $30 Primary Copay or $45 Specialist Copay	100% after you pay a $20 Primary Copay or $35 Specialist Copay
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders				
■ Hospital – Inpatient Stay	90% after you meet the Annual Deductible and pay $200 per Inpatient Stay	70% after you meet the Annual Deductible and pay $250 per Inpatient Stay	100% after you meet the Annual Deductible and pay $200 per Inpatient Stay	80% after you meet the Annual Deductible and pay $200 per Inpatient Stay

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	**Non-Network**	**Network**	**Network**
■ Physician's Office Services (Copay is per visit)	100% after you pay a $25 Primary Copay or $40 Specialist Copay	70% after you meet the Annual Deductible	100% after you pay a $30 Primary Copay or $45 Specialist Copay	100% after you pay a $20 Primary Copay or $35 Specialist Copay
Neurobiological Disorders - Physical Health Services for Autism Spectrum Disorders See also Rehabilitation Services - Outpatient Therapy				
■ Hospital – Inpatient Stay	90% after you meet the Annual Deductible and pay $200 per Inpatient Stay	70% after you meet the Annual Deductible and pay $250 per Inpatient Stay	100% after you meet the Annual Deductible and pay $200 per Inpatient Stay	80% after you meet the Annual Deductible and pay $200 per Inpatient Stay
■ Physician's Office Services (Copay is per visit)	100% after you pay a $25 Primary Copay or $40 Specialist Copay	70% after you meet the Annual Deductible	100% after you pay a $30 Primary Copay or $45 Specialist Copay	100% after you pay a $20 Primary Copay or $35 Specialist Copay

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	Non-Network	Network	Network
Nutritional Counseling ■ Hospital - Inpatient Stay	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100% after you meet the Annual Deductible	80% after you meet the Annual Deductible
■ Physician's Office Services (Copay is per visit) Limited to three visits per calendar year.	$40 Specialist Copay applies if services are received in a provider's office	70% after you meet the Annual Deductible	$40 Specialist Copay applies if services are received in a provider's office	$35 Specialist Copay applies if services are received in a provider's office
Pharmaceutical Products - Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury ■ Primary Care Provider (Copay is per visit)	100% after you pay a $25 Copay	70% after you meet the Annual Deductible	100% after you pay a $30 Copay	100% after you pay a $20 Copay
■ Specialist Physician (Copay is per visit)	100% after you pay a $40 Copay	70% after you meet the Annual Deductible	100% after you pay a $45 Copay	100% after you pay a $35 Copay

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	Non-Network	Network	Network
Pregnancy – Maternity Services				
■ Physician's Office Services (No Copay applies for routine prenatal and postnatal visits after the first visit)	100% after you pay a $25 Copay	70% after you meet the Annual Deductible	100% after you pay a $30 Copay	100% after you pay a $20 Copay
■ Physician's Office Services for Newborn	100% after you pay a $25 Primary Copay or a $40 Specialist Copay	70% after you meet the Annual Deductible	100% after you pay a $30 Primary Copay or a $45 Specialist Copay	100% after you pay a $20 Primary Copay or a $35 Specialist Copay
■ Hospital - Inpatient Stay	90% after you meet the Annual Deductible and pay $200 per Inpatient Stay	70% after you meet the Annual Deductible and pay $250 per Inpatient Stay	100% after you meet the Annual Deductible and pay $200 per Inpatient Stay	80% after you meet the Annual Deductible and pay $200 per Inpatient Stay
- well newborn	90%	70%	100%	80%
- sick newborn An Annual Deductible will apply for a newborn child whose length of stay in the Hospital is longer than the mother's length of stay for delivery of a newborn.	90% after you meet the Annual Deductible and pay $200 per Inpatient Stay	70% after you meet the Annual Deductible and pay $250 per Inpatient Stay	100% after you meet the Annual Deductible and pay $200 per Inpatient Stay	80% after you meet the Annual Deductible and pay $200 per Inpatient Stay

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	**Non-Network**	**Network**	**Network**
■ Physician Fees for Surgical and Medical Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay for delivery of a newborn.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Preventive Care Services				
■ Physician Office Services	100%	70% after you meet the Annual Deductible	100%	100%
■ Lab, X-ray or Other Preventive Tests	100%	70% after you meet the Annual Deductible	100%	100%
Prosthetic Devices	100%	70% after you meet the Annual Deductible	100%	100%

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	Non-Network	Network	Network
Reconstructive Procedures				
■ Primary Care Provider (Copay is per visit)	100% after you pay a $25 Copay	70% after you meet the Annual Deductible	100% after you pay a $30 Copay	100% after you pay a $20 Copay
■ Specialist Physician (Copay is per visit)	100% after you pay a $40 Copay	70% after you meet the Annual Deductible	100% after you pay a $45 Copay	100% after you pay a $35 Copay
■ Hospital - Inpatient Stay	90% after you meet the Annual Deductible and pay $200 per Inpatient Stay	70% after you meet the Annual Deductible and pay $250 per Inpatient Stay	100% after you meet the Annual Deductible and pay $200 per Inpatient Stay	80% after you meet the Annual Deductible and pay $200 per Inpatient Stay
■ Physician Fees for Surgical and Medical Services	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100% after you meet the Annual Deductible	80% after you meet the Annual Deductible
■ Prosthetic Devices	100%	70% after you meet the Annual Deductible	100%	100%
■ Surgery – Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	**Non-Network**	**Network**	**Network**
Rehabilitation Services and Outpatient Therapy				
■ Physician Office Services (Copay is per visit)	$5 Copay per visit for the first 20 visits. After the 20th visit, a $25 Primary Copay or a $40 Specialist Copay	70% after you meet the Annual Deductible	$5 Copay per visit for the first 20 visits. After the 20th visit, a $30 Primary Copay or a $45 Specialist Copay	$5 Copay per visit for the first 20 visits. After the 20th visit, a $20 Primary Copay or a $35 Specialist Copay
■ Hospital - Inpatient Stay	90% after you meet the Annual Deductible and pay $200 per Inpatient Stay	70% after you meet the Annual Deductible and pay $250 per Inpatient Stay	100% after you meet the Annual Deductible and pay $200 per Inpatient Stay	80% after you meet the Annual Deductible and pay $200 per Inpatient Stay
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Up to 60 days per calendar year	90% after you meet the Annual Deductible and pay $200 per Inpatient Stay	70% after you meet the Annual Deductible and pay $250 per Inpatient Stay	100% after you meet the Annual Deductible and pay $200 per Inpatient Stay	80% after you meet the Annual Deductible and pay $200 per Inpatient Stay

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	Non-Network	Network	Network
Spinal Treatment (Copay is per visit) Up to 3 modalities per treatment Up to 30 treatments per calendar year	100% after you pay a $25 Primary Copay	70% after you meet the Annual Deductible	100% after you pay a $30 Primary Copay	100% after you pay a $20 Primary Copay
Substance Use Disorder Services				
■ Hospital - Inpatient Stay (Copay is per admission)	90% after you meet the Annual Deductible and pay $200 per Inpatient Stay	70% after you meet the Annual Deductible and pay $250 per Inpatient Stay	100% after you meet the Annual Deductible and pay $200 per Inpatient Stay	80% after you meet the Annual Deductible and pay $200 per Inpatient Stay
■ Physician's Office Services (Copay is per visit)	100% after you pay a $25 Primary Copay or $40 Specialist Copay	70% after you meet the Annual Deductible	100% after you pay a $30 Primary Copay or $45 Specialist Copay	100% after you pay a $20 Primary Copay or $35 Specialist Copay

Covered Health Services	CHOICE PLUS Percentage of Eligible Expenses Payable by the Plan:		EPO CHOICE Percentage of Eligible Expenses Payable by the Plan:	COINSURED CHOICE Percentage of Eligible Expenses Payable by the Plan:
	Network	Non-Network	Network	Network
Surgery – Outpatient See also Physician Fees for Surgical and Medical Services				
■ Outpatient Surgery-Facility	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100% after you meet the Annual Deductible	80% after you meet the Annual Deductible
■ Outpatient Surgery-Physician's Office Service	100% after you pay a $25 Primary Copay or $40 Specialist Copay	70% after you meet the Annual Deductible	100% after you pay a $30 Primary Copay or $45 Specialist Copay	100% after you pay a $20 Primary Copay or $35 Specialist Copay
Therapeutic Treatments – Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Transplantation Services See Section 6, *Additional Coverage Details*, for notification requirements.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible	100% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Urgent Care Center Services (Copay is per visit)	100% after you pay a $25 Copay	70% after you meet the Annual Deductible	100% after you pay a $25 Copay	100% after you pay a $25 Copay

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to notify Personal Health Support before you receive them, and any reduction in Benefits that may apply if you do not call Personal Health Support.

This section supplements the second table in Section 5, *Plan Highlights*.

While the second table in Section 5 provides you with some of the benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, and Covered Health Services for which you must call Personal Health Support. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions*.

Acupuncture Services

The Plan pays for acupuncture services provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine;
- Doctor of Osteopathy;
- Chiropractor; or
- Acupuncturist.

Covered Health Services include:

- pain therapy
- treatment of nausea as a result of:
  - chemotherapy;
  - first trimester of Pregnancy; and
  - post-operative procedures.

Each treatment is limited to 3 modalities during a visit. Covered Health Services are limited to a total of 30 treatments per calendar year.

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that is medically equipped to provide the needed Emergency Room Health Services. See Section 14, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Room Health Services.

In most cases, UnitedHealthcare will coordinate and direct non-Emergency ambulance transportation. The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- from a Non-Network Hospital to a Network Hospital;
- to a Hospital that provides a higher level of care that was not available at the original Hospital;
- to a more Cost-Effective acute care facility; or
- from an acute facility to a sub-acute setting.

If you are requesting non-Emergency ambulance services, you must notify Personal Health Support as soon as possible before the transport. If Personal Health Support is not notified, you will be responsible for paying all charges and no Benefits will be paid.

Cancer Resource Services (CRS)

Cancer Resource Services is a program administered by UnitedHealthcare or its affiliates made available to you by Travis County. The CRS program provides:

- specialized consulting services, on a limited basis, to Covered Persons with cancer;
- access to cancer centers with expertise in treating the most rare or complex cancers; and
- education to help patients understand their cancer and make informed decisions about their care and course of treatment.

The Plan pays Benefits for oncology services provided by Designated Facilities participating in the Cancer Resource Services (CRS) program even if the facility is not a Network Facility. Designated Facility is defined in Section 14, *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If a Covered Person has cancer, you may:

- be referred to CRS by a Personal Health Support Nurse;
- call CRS toll-free at (866) 936-6002; or
- visit www.urncrs.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Facility. If you receive oncology services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay;
- Surgery - Outpatient;
- Diagnostic Outpatient – Facility; and
- Therapeutic Services - –CT, Pet Scans, MRI and Nuclear Medicine – Outpatient

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with cancer-related services received at a Designated Facility.

To receive Benefits under the CRS program, you must contact CRS before obtaining Covered Health Services.

Colonoscopies and other Scopies

The Plan pays for diagnostic and therapeutic scopic procedures and related services including laboratory charges received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment;
- laboratory charges, and
- Physician services for anesthesiologists, pathologists and radiologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services.*

Please note that Benefits under this section do include scopic procedures, which are for the purpose of performing surgery. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD services:

- outpatient diagnostic testing;
- evaluation;
- surgical interventions;
- interventional cardiac catheterizations (insertion of a tubular device in the heart);
- fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology); and
- approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks or Personal Health Support to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the toll-free number on your ID card for information about CHD services.

If you receive Congenital Heart Disease services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments – Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program.

Dental Services - Accident Only

Dental services are covered by the Plan only when all of the following are true:

- treatment is necessary because of damage resulting from accidental injury or radiation therapy or chemotherapy that occurred while the Covered Person is covered by this Plan;
- dental damage does not occur as a result of normal activities of daily living, such as chewing or eating ice, or extraordinary use of the teeth;

- the Physician or dentist has certified that the pre-damage condition of the injured tooth was that of a sound, natural tooth, or a restored tooth, or a prosthesis in good condition;
- dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and
- in the case of damage from accidental injury, the dental damage is severe enough that initial contact with a Physician or dentist occurs within 96 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the accidental Injury and if extenuating circumstances exist due to the severity of the accidental Injury.)

Only the least costly, dentally necessary treatment to restore the injured tooth to its pre-damage condition will be considered a Covered Benefit in these circumstances. Dental services for final treatment to repair the damage caused by accidental Injury must be started within three months of the accident unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident. Dental services to repair the damage caused by radiation therapy or chemotherapy must be started within three months of the diagnosis of the damage unless extenuating circumstances exist (such as prolonged therapy causing additional damage) and completed within 12 months of the diagnosis.

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to direct treatment of acute traumatic Injury and damage due to radiation therapy and chemotherapy.

The Plan pays for treatment of damage resulting from accidental Injury or radiation therapy or chemotherapy only for:

- emergency examination;
- necessary diagnostic x-rays;
- endodontic (root canal) treatment;
- temporary splinting of teeth;
- prefabricated post and core;
- simple minimal restorative procedures (fillings);
- extractions;
- post-traumatic crowns if such are the only clinically acceptable treatment; and
- replacement of teeth lost due to the Injury.

You should notify Personal Health Support as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins if you have accidental Injury. You do not have to provide notification before the initial Emergency treatment. When you provide notification, Personal Health Support can determine whether the service is a Covered Health Service.

Diagnostic Procedures Outpatient

Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:

- Lab;
- Radiology/X-ray; and
- Mammography testing.

Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a Physician's office, Benefits are described under Physician's Office Services below.

Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine

Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including CT scans, PET scans, MRI, and nuclear medicine.

Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a Physician's office, Benefits are described under Physician's Office Services below.

Disposable Medical Supplies and Equipment

The Plan covers Disposable Medical Supplies that meet each of the following criteria:

- Ordered or provided by a Physician for outpatient use.
- Used for medical purposes to treat a Sickness, Injury or their symptoms.
- Not generally useful to a person in the absence of a Sickness, Injury or their symptoms.
- Appropriate for use in the home.
- Available through a medical supplier and not generally available in grocery or general merchandise stores.

Examples of Disposable Medical Supplies include the following:

- Two medically appropriate pairs of elastic stockings each year,
- Gauze and dressings when used with Durable Medical Equipment.
- Ostomy Supplies:
  - Pouches, Face Plates and belts
  - Irrigation sleeves, bags and catheters
  - Skin Barriers
  - Deodorants
  - Filters
  - Lubricants
  - Tape
  - Appliance Cleaners
  - Adhesive and Adhesive Remover

- Diabetic Self-Management Items including the following:
  - Standard insulin syringes with needles,
  - Blood testing strips – glucose,
  - Urine testing strips – glucose,
  - Ketone testing strips and tablets,
  - Lancets and lancet devices,
  - Glucometers (every two years)
- Inhaler spacers.
- Intravenous tubing.
- Respiratory therapy supplies.
- Oxygen and tubing, connectors and masks necessary to administer oxygen or for delivery pumps for tube feedings when used with Durable Medical Equipment.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- ordered or provided by a Physician for outpatient use;
- used to serve a medical purpose with respect to treatment of a Sickness, Injury or disability;
- not consumable or disposable;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use and primarily used in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you may be responsible for any cost difference between the piece you rent or purchase and the piece UnitedHealthcare has determined is the most Cost-Effective.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- standard Hospital beds;
- delivery pumps for tube feedings;
- burn garments;

- insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section;
- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces to treat curvature of the spine. Braces that straighten or change the shape of a body part such as arm, leg and neck. (However orthotic shoes or shoes with inserts are excluded from coverage unless attached to a brace. Dental braces are excluded from coverage.); and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

In conjunction with cochlear implantation, Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. ***Note:*** DME is different from prosthetic devices – see *Prosthetic Devices* in this section.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every three calendar years, if functionally necessary.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than three years. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at anytime and are not subject to the three year timeline for replacement.

If you are enrolled in the Choice Plus Plan, for Non-Network Benefits you must notify Personal Health Support if the purchase, rental, repair or replacement of DME will cost more than $1,000. You must purchase or rent the DME from the vendor Personal Health Support identifies. If Personal Health Support is not notified, Benefits will be subject to a $250 penalty. This notification does not apply if you are enrolled in the Choice or CoInsured Plans.

Emergency Room Health Services - Outpatient

The Plan's Emergency Room Health Services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

Regardless of the Plan in which you are enrolled, if you are admitted as an inpatient to a Network Hospital for the same condition within 24 hours of receiving treatment for an Emergency Room Health Service, you will not have to pay the Copay for Emergency Room Health Services. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.

If you are enrolled in the Choice Plus Plan, Network Benefits will be paid for an Emergency admission to a Non-Network Hospital as long as Personal Health Support is notified within one business day of the admission or on the same day of admission if reasonably possible after you are admitted to a Non-Network Hospital. If you continue your stay in a Non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Non-Network Benefits will apply.

If you are enrolled in the Choice, or CoInsured Plans, Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as Personal Health Support is notified within one business day of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, no Benefits will be paid.

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

If you are enrolled in the Choice Plus Plan, you must notify Personal Health Support within one business day of the admission or on the same day of admission if reasonably possible if you are admitted to a Non-Network Hospital as a result of an Emergency. If Personal Health Support is not notified, Benefits for the Inpatient Hospital Stay will be subject to a $250 penalty. This notification does not apply if you are enrolled in the Choice or CoInsured Plans.

Eye Examinations and Vision Therapy

Eye examinations received from a health care provider in the provider's office. Network Benefits include one routine vision exam, including refraction, to detect vision impairment by a Network Provider each calendar year. Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

Vision therapy (Synonyms include: eye muscle exercise therapy, optometric visual therapy, vision training, orthoptic training and pleoptic training).

Orthoptic training (Vision therapy) is limited to a lifetime maximum of 20 visits for each Employee or adult Dependent. Covered Services are limited to a lifetime maximum of 30 visits for each Dependent child.

Home Health Care

Home Health Care Services are services that require clinical training to be delivered safely and effectively and are provided by a program or organization authorized by law to provide health care services in the home if you need care in your home due to the nature of your condition. Services must be:

- ordered by a Physician;
- provided in your home by a registered nurse, or by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- provided to obtain a specified medical outcome and provide for your safety as a patient;
- provided on a part-time, intermittent schedule.

Personal Health Support will decide if Skilled Care is needed 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.
- assistance is needed with activities of daily living, which include but are not limited to dressing, feeding, bathing, ostomy care, incontinence care, checking of routine vital signs, or transferring from a bed to a chair or ambulating.

If you are enrolled in the Choice Plus Plan, please remember for Non-Network Benefits, you must notify Personal Health Support five business days before receiving services or as soon as reasonably possible. If Personal Health Support is not notified, Benefits will be subject to a $250 penalty. This notification does not apply if you are enrolled in the Choice or CoInsured Plans.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

If you are enrolled in the Choice Plus Plan, please remember for Non-Network Benefits, you must notify Personal Health Support one business days before receiving services. If Personal Health Support is not notified, Benefits will be subject to a $250 penalty. This notification does not apply if you are enrolled in the Choice or CoInsured Plans.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- non-Physician services and supplies received during an Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); or a private room where a semi-private is not available or a private room is appropriate in terms of generally accepted medical practice and
- Physician services for anesthesiologists, Emergency room Physicians, consulting Physicians, pathologists and radiologists.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Room Health Services - Outpatient* and *Surgery - Outpatient, Scopic Procedures - Diagnostic and Therapeutic Services*, and *Therapeutic Treatments - Outpatient*, respectively.

If you are enrolled in the Choice Plus Plan, please remember for Non-Network Benefits, you must notify Personal Health Support as follows:

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

If Personal Health Support is not notified, Benefits will be subject to a $250 penalty. This notification does not apply if you are enrolled in the Choice or CoInsured Plans.

Allergy Injections received in a Physician's Office

The Plan pays for Benefits for allergy serum injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.

When other health services are received, Benefits are described under *Physician's Office Services*.

Allergists are considered as primary care.

When you go to the Physician's office and get an allergy shot from the nurse and do not receive any additional services, you will not be required to pay a copay, coinsurance or deductible.

When additional services are received during your visit to the Physician's office to receive an allergy shot, Benefits will be paid as described under Physician's Office Services.

Injections received in a Physician's Office

The Plan pays for Benefits for injections received in a Physician's office when no other health service is received.

When other health services are received, Benefits are described under *Physician's Office Services*.

Kidney Resource Services (KRS)

Kidney Resource Services (KRS) is a program that provides:

- specialized consulting services to Covered Persons with End Stage Renal Disease (ESRD) or chronic kidney disease;
- access to dialysis centers with expertise in treating kidney disease; and
- guidance for the patient on the prescribed plan of care.

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) disease provided by Designated Facilities participating in the Kidney Resource Services (KRS) program. Designated Facility is defined in Section 14, *Glossary*.

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self refer to a Network provider participating in the program. Notification is required:

- prior to vascular access placement for dialysis; and
- prior to any ESRD services.

A Covered Person may:

- be referred to KRS by Personal Health Support; or
- call KRS toll-free at (888) 936-7246 and select the KRS prompt.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Facility. If you receive services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services.

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, group therapeutic services and provider-based case management services; and
- crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Outpatient Benefits include Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for the inpatient treatment. 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.

Special Mental Health 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 Services benefit. The Mental Health Services Benefits and financial requirements assigned to 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 which may not otherwise be covered under this Plan. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

If you are enrolled in the Choice Plus Plan, please remember for Non-Network Benefits, you must notify the Mental Health/Substance Use Disorder Administrator to receive inpatient Benefits in advance of any treatment. Please call the phone number that appears on your ID card. Without notification, Benefits will be subject to a $250 penalty. This notification does not apply if you are enrolled in the Choice or CoInsured Plans.

Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders

These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorders. The Plan only pays Benefits for psychiatric services for Autism Spectrum Disorders that are both of the following:

- provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and
- focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others or property or that are impairing daily functioning or both.

Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders 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, group therapeutic services and provider-based case management services; and
- crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Outpatient Benefits include 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.

Note: 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.

If you are enrolled in the Choice Plus Plan, for Non-Network Benefits, you must notify the Mental Health/Substance Use Disorder Administrator to receive inpatient Benefits. Please call the phone number that appears on your ID card. Without notification, Benefits will be subject to a $250 penalty. This notification does not apply if you are enrolled in the Choice or CoInsured Plans.

Neurobiological Disorders – Physical Health Services for Autism Spectrum Disorders

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

- diagnostic evaluations and assessment services;
- applied behavior analysis;
- behavior training and behavior management;
- speech therapy;
- occupational therapy;
- physical therapy; or
- medications or nutritional supplements used to address symptoms of autism spectrum disorder.

Note: 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.

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional when:

- education is required for a disease in which patient self-management is an important component of treatment; and
- there exists a knowledge deficit about the disease which requires the intervention of a trained health professional.

Nutritional Counseling is limited to three visits per calendar year.

Some examples of such medical conditions include:

- coronary artery disease;
- congestive heart failure;
- severe obstructive airway disease;
- gout (a form of arthritis);
- renal failure;
- phenylketonuria (a genetic disorder diagnosed at infancy);
- hyperlipidemia (excess of fatty substances in the blood); and
- diabetes.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered by or the administration of which must be directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility, Outpatient Surgical Facility and Physicians office, or for Physician house calls.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services received in a Physician's office for the evaluation and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital. Benefits under this section include allergy injections, allergy testing, and hearing exams in case of Injury or Sickness.

When you go to the Physician's office and get an allergy shot from the nurse and you receive additional services, such as allergy testing, you will be required to pay a copay or coinsurance after satisfying the applicable deductible.

When a Physician performs professional services to mix the allergy serum, the fees for this are not subject to the copay.

Benefits for preventive services are described under *Preventive Care* in this section

Benefits under this section include lab, radiology/x-ray or other diagnostic services performed in the Physician's office.

Please Note
Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Covered Mother

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, delivery, postnatal care, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

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

These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer stays. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Examples of additional Covered Services related to pregnancy are:

- Birthing Center Services including room and board, anesthetics.
- Nurse-Midwife services by a licensed or certified Nurse-Midwife.
- Routine Well Baby care before the mother is released from the hospital including nursery care, circumcision by a surgeon and Physician services when the baby is healthy.

If you are enrolled in the Choice Plus Plan, for Non-Network Benefits, you must notify Personal Health Support as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above. If Personal Health Support is not notified, Benefits for the extended stay will be subject to a $250 penalty. This notification does not apply if you are enrolled in the Choice or CoInsured Plans.

If the mother is sick and is inpatient longer than the federally mandated requirements stated above, but the newborn is discharged from the hospital, any fees for the newborn to continue to stay are not covered by the Plan.

The annual deductible is waived on the newborn's fees during the time when the mother and newborn are in the hospital together. This annual deductible waiver applies to all of the newborn's eligible inpatient claims including, but not limited to, physician fees and facility fees. However, if the newborn stays longer than the mother the newborn's annual deductible will apply upon the mother's discharge from the hospital.

Newborn Benefits when Mother is not Covered under the Plan

If the newborn's birth mother is not covered under the Plan, the baby's annual deductible is not waived. The Plan applies the newborn's coinsurance and deductible under the newborn.

Healthy moms and healthy babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Resources to Help you Stay Healthy*, for details.

Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital include medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes. The services in the following four bullets are required under applicable law. The details about these services are found online at the sites listed:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; You can find the list of preventive services that have a rating of "A" or "B" from the USPSTF by visiting http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration found online at http://www.hrsa.gov/index.html; and
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. Current recommendations and wellness guidelines for specific populations are found online at http://www.ahrq.gov/.

You will find examples of services on those sites.

Prosthetic Devices

The Plan pays for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- artificial arms, legs, feet and hands;
- artificial eyes, ears and nose; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would

have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are provided for the replacement of a type of prosthetic device once every three calendar years.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a necessary mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. 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 UnitedHealthcare at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure may be to improve the appearance of a body part and the procedure is cosmetic. Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are also considered Cosmetic Procedures. An example of this is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, *Glossary*.

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.

You must notify Personal Health Support five business days before undergoing any Reconstructive Procedure. When you provide notification, Personal Health Support can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage.

Rehabilitation Services - Outpatient Therapy

The Plan provides short-term outpatient rehabilitation services for the following types of therapy:

- physical therapy;
- occupational therapy;
- speech therapy;
- post-cochlear implant aural therapy;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider must perform the services under the direction of a Physician. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

The Plan will pay Benefits for speech therapy only when the speech impediment or dysfunction results from Injury, Sickness, stroke, cancer, Autism Spectrum Disorders or a Congenital Anomaly, or is needed following the placement of a cochlear implant.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

When Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan, Benefits include:

- non-Physician services and supplies received during the Inpatient Stay; and
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for anesthesiologists, consulting Physicians, pathologists and radiologists.

Benefits are available when Skilled Care and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

UnitedHealthcare will determine if Benefits are available by reviewing both the skill level of the services required 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 available only if:

- the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost-Effective alternative to an Inpatient Stay in a Hospital; and
- you will receive primarily Skilled Care services that are not primarily Custodial Care as described in Section 8, *Exclusions*.

Skilled Care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

- it is 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; and
- it requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care as described in Section 8, *Exclusions,* or domiciliary care, even if ordered by a Physician.

Benefits are limited to a total of 60 days per calendar year.

If you are enrolled in the Choice Plus Plan, for Non-Network Benefits, you must notify Personal Health Support as follows:

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

If Personal Health Support is not notified, Benefits will be subject to a $250 penalty. This notification does not apply if you are enrolled in the Choice or CoInsured Plans.

Spinal Treatment

A Spinal Treatment is using manual or mechanical means to detect or correct subluxation in the body to remove nerve interface or its effects. The interference must result from or relate to distortion, misalignment or subluxation of or in the vertebral column.

Benefits for Spinal Treatment are only covered when provided by an appropriately licensed provider in the provider's office. Benefits include diagnosis and related services and are limited to three modalities of treatment per day. Benefits for Spinal Treatment are limited to a combined total of 30 visits per calendar year.

Soft tissue modalities are a Covered Health Service when performed in an office setting by a covered provider.

Substance Use Disorder Services

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.

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

- diagnostic evaluations and assessment;
- treatment planning;
- referral services;
- medication management;
- individual, family, group therapeutic services and provider-based case management;
- crisis intervention; and
- detoxification (sub-acute/non-medical).

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Outpatient Benefits include Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for the inpatient treatment. 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.

Special 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 Substance Use Disorder Services benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to 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 substance use disorder which may not otherwise be covered under this Plan. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

If you are enrolled in the Choice Plus Plan, for Non-Network Benefits, you must notify the Mental Health/Substance Use Disorder Administrator to receive inpatient Benefits. Please call the phone number that appears on your ID card. Without notification, Benefits will be subject to a $250 penalty. This notification does not apply if you are enrolled in the Choice or CoInsured Plans.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- education is required for a disease in which patient self-management is an important component of treatment; and
- there exists a knowledge deficit about the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- the facility charge and the charge for related supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists.
- Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

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

Transplantation Services

Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a provider. The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Examples of transplants for which Benefits are available include but are not limited to:

- heart;
- heart/lung;
- lung;
- kidney;
- kidney/pancreas;
- liver;
- liver/kidney;
- liver/intestinal;
- pancreas;
- intestinal;
- bone marrow (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), and
- cornea transplants that are provided by a provider at a Hospital. (You are not required to notify United Resource Networks or Personal Health Support of a cornea transplant).

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Plan has specific guidelines about Benefits for transplant services. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the telephone number on your ID card for information about these guidelines.

If you are enrolled in the Choice Plus Plan, for Non-Network Benefits, you must notify United Resource Networks or Personal Health Support as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If United Resource Networks or Personal Health Support is not notified, Benefits will be subject to a $250 penalty. This notification does not apply if you are enrolled in the Choice or CoInsured Plans.

Travel and Lodging

United Resource Networks or Personal Health Support will assist the patient and family with travel and lodging arrangements related to:

- Congenital Heart Disease (CHD);
- transplantation services; and
- cancer-related treatments.

Provided the patient is not covered by Medicare, the Plan covers expenses for travel and lodging for the patient and a companion as follows:

- transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the cancer-related treatment, the CHD service, or the transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up;
- Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion. Benefits are paid at a per day rate of up to $100 per day for the patient or up to $200 per day for the patient plus one companion; or
- if the patient is an enrolled dependent minor child, the transportation of the patient and up to two companions who are traveling to and/or from the site of the transplant and Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and up to two companions. Benefits are paid at a per day rate of up to $100 per day for the patient or up to $300 per day for the patient plus two companions.

Travel and lodging expenses are only available if the recipient lives more than 50 miles from the facility for CRS and transplantation or the CHD facility. UnitedHealthcare must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

- airfare at coach rate or economy class;
- taxi or ground transportation; or
- mileage reimbursement at the IRS rate for the most direct route between the patient's home and the facility.

Support in the event of serious illness
If a Covered Person has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *Glossary*.

When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section.

SECTION 7 - RESOURCES TO HELP YOU STAY HEALTHY

What this section includes:
Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools;
- Disease and Condition Management Services; and
- Wellness Programs.

Travis County believes in giving you the tools you need to be an educated health care consumer. To that end, Travis County has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:
Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and Travis County are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Consumer Solutions and Self-Service Tools

Health Assessment

You and all of your Covered Dependents are invited to learn more about your health and wellness at **www.myuhc.com** and are encouraged to participate in the online health assessment. The health assessment is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health assessment is kept confidential. Completing the assessment will not impact your Benefits or eligibility for Benefits in any way.

To find the health assessment, log in to **www.myuhc.com**. After logging in, access your personalized *Health & Wellness* page and click the *Health Assessment* link. If you need any assistance with the online assessment, please call the number on the back of your ID card.

Health Improvement Plan

You can start a Health Improvement Plan at any time. This plan is created just for you and includes information and interactive tools, plus online health coaching recommendations based on your profile.

Online coaching is available for:

- nutrition;
- exercise;
- weight management;
- stress;
- smoking cessation;
- diabetes; and
- heart health.

To help keep you on track with your Health Improvement Plan and online coaching, you'll also receive personalized messages and reminders – Travis County's way of helping you meet your health and wellness goals.

NurseLine℠

NurseLine is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, and seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that Travis County has available to help you improve your health and well-being or manage a chronic condition. Consider putting the NurseLine number in your cell phone directory so that you can call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take Prescription Drugs safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

Your child is running a fever and it's 1:00 AM. What do you do?

Call NurseLine toll-free, any time, 24 hours a day, and seven days a week. You can count on NurseLine to help answer your health questions.

Note: If you have a medical Emergency, call 911 instead of calling NurseLine.

NurseLine gives you another convenient way to access health information either on the telephone or on-line. By calling the same toll-free number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine is available to you at no cost.

With NurseLine, you also have access to nurses online. To use this service, log onto **www.myuhc.com** and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, and seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Note: If you have a medical Emergency, call 911 instead of logging onto **www.myuhc.com**.

Reminder Programs

To help you stay healthy, UnitedHealthcare may send Covered Persons reminders to schedule recommended screening exams. Examples of reminders include:

- mammograms for women;
- pediatric and adolescent immunizations;
- cervical cancer screenings for women between the ages of 20 and 64;
- comprehensive screenings for individuals with diabetes; and
- influenza/pneumonia immunizations for enrollees age 65 and older.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

Treatment Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Treatment Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer;
- coronary disease.

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care; and

- information on high quality providers and programs.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information about the program, please contact the number on the back of your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for Network providers available in your Plan through the online provider directory;
- access all of the content and wellness topics from NurseLine including Live Nurse Chat 24 hours a day, seven days a week;
- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com
If you have not already registered as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your UnitedHealthcare ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Copays, Coinsurance, and Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or, print a temporary ID card.
- research health topics of interest to you.
- learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease and Condition Management Services

HealtheNotes℠

UnitedHealthcare provides a service called HealtheNotes to help educate Members and make suggestions about your medical care. HealtheNotes provides you and your Physician with suggestions about preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 14, *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions about your health and the identified suggestions. Any decisions about your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Wellness Programs

Healthy Pregnancy and Parenting Program

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. This program offers:

- Pregnancy consultation to identify special needs;
- written and on-line educational materials and resources;
- 24-hour toll-free access to experienced maternity nurses;
- a phone call from a care coordinator during your Pregnancy, to see how things are going; and
- a phone call from a care coordinator approximately four weeks after delivery to give you additional information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time. To enroll, call the toll-free number on the back of your ID card.

As a program Member, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

SECTION 8 - EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Additional Coverage Details.*

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the SPD says "this includes," or "including but not limiting to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

Alternative Treatments

1. acupressure
2. aromatherapy;
3. hypnotism;
4. massage therapy;
5. Rolfing (holistic tissue massage);
6. Ecological or environmental medicine, diagnosis or treatment.
7. Herbal medicine, holistic or homeopathic care, including drugs. and
8. art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complimentary and Alternative Medicine (NCCAM) of the National Institutes of Health.

This exclusion does not apply to Spinal Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, *Additional Coverage Details.*

Dental

1. dental care, except as identified under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*;

   Endodontics, periodontal surgery and restorative treatment are excluded.

2. diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include:

   - extractions (including wisdom teeth);
   - restoration and replacement of teeth;
   - medical or surgical treatments of dental conditions; and
   - services to improve dental clinical outcomes;

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details*.

3. dental implants , bone grafts, and other implant-related procedures;

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details*.

4. dental braces (orthodontics);

5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia; and the only exceptions to this are for the direct treatment of acute traumatic Injury.

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in Section 6, *Additional Coverage Details*.

6. treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

Devices, Appliances and Prosthetics

1. devices used specifically as safety items or to affect performance in sports-related activities;

2. orthotic appliances and devices that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*:

   Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.

3. the following items are excluded, even if prescribed by a Physician:

   - enuresis alarm;
   - non-wearable external defibrillator;
   - trusses;
   - ultrasonic nebulizers;

4. the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect;

5. the replacement of lost or stolen prosthetic devices;

6. devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details* ; and

7. oral appliances for snoring.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See Section 15, *Prescription Drugs*, for coverage details and exclusions for that separate benefit.

1. Prescription Drugs for outpatient use that are filled by a prescription order or refill;

2. self-injectable medications (This exclusion does not apply to medications which, due to their characteristics, as determined by UnitedHealthcare, must typically be administered or the administration of which must be directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting);

3. growth hormone therapy;

4. non-injectable medications given in a Physician's office except as required in an Emergency and consumed in the Physician's office; and

5. over the counter drugs and treatments.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services or Unproven Services, unless the Plan has agreed to cover them on an exception basis as described in the *Glossary*.

   This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

Foot Care

1. routine foot care including:

- cutting or removal of corns and calluses;
- nail trimming or cutting; and
- debriding (removal of dead skin or underlying tissue);

2. hygienic and preventive maintenance foot care. Examples include:

- cleaning and soaking the feet;
- applying skin creams in order to maintain skin tone; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot;

  This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

3. treatment of flat feet;

4. treatment of subluxation of the foot;

5. shoe inserts;

6. arch supports;

7. shoes (standard or custom), lifts and wedges; and

8. shoe orthotics unless they are attached to a brace.

Medical Supplies and Equipment

1. prescribed or non-prescribed medical supplies. An example of supplies that are not covered includes but is not limited to more than two pairs of medically approved elastic stockings per year.

This exclusion does not apply to:

- ostomy bags and related supplies for which Benefits are provided as described under *Disposable Medical Supplies* in Section 6, *Additional Coverage Details*.
- disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Disposable Medical Supplies* in Section 6, *Additional Coverage Details*; or
- diabetic supplies for which Benefits are provided as described under *Disposable Medical Supplies* in Section 6, *Additional Coverage Details*.

2. tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment;

3. the repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect;

4. the replacement of lost or stolen Durable Medical Equipment; and

5. deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Disposable Medical Supplies* in Section 6, *Additional Coverage Details*.

Mental Health/Substance Use Disorder

Exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders* and/or *Substance Use Disorder Services* in Section 6, *Additional Coverage Details*.

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;
   - 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 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 and paraphilias (sexual behavior that is considered deviant or abnormal);

6. educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning except as identified in *Neurobiological Disorders – Physical Health Services for Autism Spectrum Disorders;*

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*;

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. 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.

Nutrition

1. nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy;

2. nutritional counseling for either individuals or groups, except as defined under *Nutritional Counseling* in Section 6, *Additional Coverage Details*;

3. food of any kind. Foods that are not covered include:

   - enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded;
   - foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
   - oral vitamins and minerals;
   - meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
   - other dietary and electrolyte supplements; and

4. health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. television;

2. telephone;

3. beauty/barber service;

4. guest service;

5. supplies, equipment and similar incidentals for personal comfort. Examples include:

- air conditioners;
- air purifiers and filters;
- batteries and battery chargers;
- dehumidifiers and humidifiers;
- ergonomically correct chairs;
- non-Hospital beds, comfort beds, motorized beds and mattresses;
- breast pumps;
- car seats;
- chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
- electric scooters;
- exercise equipment and treadmills;
- hot tubs, Jacuzzis, saunas and whirlpools;
- medical alert systems;
- music devices;
- personal computers;
- pillows;
- power-operated vehicles;
- radios;
- strollers;
- safety equipment;
- vehicle modifications such as van lifts;
- video players; and
- home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

Physical Appearance

1. Cosmetic Procedures, as defined in Section 14, *Glossary*, are excluded from coverage. Examples include:

    - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
    - pharmacological regimens;
    - nutritional procedures or treatments;
    - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
    - hair removal or replacement by any means;
    - treatments for skin wrinkles or any treatment to improve the appearance of the skin;
    - treatment for spider veins;
    - skin abrasion procedures performed as a treatment for acne;
    - treatments for hair loss;
    - varicose vein treatment of the lower extremities, when it is considered cosmetic; and
    - replacement or removal of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;

2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments, and diversion or general motivation;

3. weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity;

4. wigs or toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness regardless of the reason for the hair loss; and

5. treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. biofeedback except when prescribed by a Physician for pain management;

2. medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer);

3. rehabilitation services and Spinal Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including but not limited to routine, long-term or maintenance/preventive treatment;

4. speech therapy to treat stuttering, stammering, or other articulation disorders;

5. speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, a Congenital Anomaly or Autism Spectrum Disorders as identified under *Rehabilitation Services – Outpatient Therapy* in Section 6, *Additional Coverage Details*;

6. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;

7. excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty);

8. psychosurgery (lobotomy);

9. treatment of tobacco dependency;

10. chelation therapy, except to treat heavy metal poisoning;

11. Spinal Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, alignment of the vertebral column, such as asthma or allergies;

12. physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter;

13. sex transformation operations;

14. the following treatments for obesity:

    - non-surgical treatment, even if for morbid obesity; and
    - surgical treatment of obesity even if there is a diagnosis of morbid obesity;

15. medical and surgical treatment of hyperhidrosis (excessive sweating);

16. services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered medical or dental in nature;

17. upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumor or cancer. Orthognathic surgery (procedure to correct underbite or overbite) jaw alignment and treatment for the temporomandibular joint, except as treatment of obstructive sleep apnea; and

18. breast reduction except coverage that is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

Providers Services:

1. performed by a provider who is a family member by birth or marriage, including your Spouse, Domestic Partner, Sponsored Dependent, brother, sister, parent or child as described in eligibility in Section 2, *Introduction*;

2. a provider may perform on himself or herself;

3. performed by a provider with your same legal residence;

4. ordered or delivered by a Christian Science practitioner;

5. performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;

6. provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider;

7. which are self-directed to a free-standing or Hospital-based diagnostic facility; and

8. ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:

    - before ordering the service; or
    - after the service is received.

    This exclusion does not apply to mammography testing.

Reproduction

1. health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment

   This exclusion does not apply to diagnosis of infertility.

2. storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue);

3. expenses for surrogate parenting, donor eggs, donor sperm and host uterus;

4. the reversal of voluntary sterilization;

5. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;

6. services provided by a doula (labor aide); and

7. parenting, pre-natal or birthing classes.

Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB)*;

2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;

3. while on active military duty; and

4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

Transplants

1. health services for organ and tissue transplants, except as identified under *Transplantation Services* in Section 6*, Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;

2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and

3. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan)

Travel

1. health services provided in a foreign country, unless required as Emergency Room Health Services; and

2. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services may be reimbursed at the Plan's discretion.

Types of Care

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care;
2. domiciliary care, living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services;
3. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;
4. Private Duty Nursing;
5. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 6, *Additional Coverage Details*;
6. rest cures;
7. services of personal care attendants;
8. work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. implantable lenses used only to correct a refractive error (such as Intacs corneal implants);

2. purchase cost and associated fitting charges for eyeglasses or contact lenses;

3. hearing aids;

4. eye exercise or vision therapy; and

5. surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. autopsies and other coroner services and transportation services for a corpse;

2. charges for:

   - missed appointments;
   - room or facility reservations;
   - completion of claim forms; or
   - record processing.

3. charges prohibited by federal anti-kickback or self-referral statutes;

4. diagnostic tests that are:

   - delivered in other than a Physician's office or health care facility; and
   - self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;

5. expenses for health services and supplies:

   - that do not meet the definition of a Covered Health Service in Section 14, Glossary;
   - that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;
   - that are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
   - that are received before the date your coverage under this Plan begins,
   - 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 this Benefit Plan; or
   - that exceed Eligible Expenses or any specified limitation in this SPD;
   - for which a Non-Network provider waives the Copay, Annual Deductible or Coinsurance amounts;

6. foreign language and sign language services;

7. long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products;

8. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

   - required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration;
   - conducted for purposes of medical research;
   - related to judicial or administrative proceedings or orders; or

- required to obtain or maintain a license of any type;

9. education, training, and bed and board while in an institution which is mainly a school, training institution, a place of rest or a place for the aged;

10. charges made by a Hospital for non-acute care services that may be covered when provided by other appropriate providers.

SECTION 9 - CLAIMS PROCEDURES

What this section includes:

- How Network and Non-Network claims work; and
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Copay or Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Copay or Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a Non-Network provider, you (or the provider if they prefer) should send the bill with a claim form to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached to the bill and both mailed to UnitedHealthcare at the address on the back of your ID card. This does not apply if you are enrolled in the EPO Choice or CoInsured Choice Plans, unless you receive Emergency Room Health Services.

Prescription Drug Benefit Claims

If you wish to receive reimbursement for a prescription, you may submit a post-service claim as described in this section if:

- you are asked to pay the full cost of the Prescription Drug when you fill it and you believe that the Plan should have paid for it; or
- you pay a Copay and you believe that the amount of the Copay was incorrect.

If a pharmacy (retail or mail order) fails to fill a prescription that you have presented and you believe that it is a Covered Health Service, you may submit a pre-service request for Benefits as described in this section.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the toll-free number on your ID card or contacting the Risk and Benefit Manager in the Human Resources Management Department. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
- the patient's name, age and relationship to the Member;
- the group number as shown on your ID card;
- the name, address and tax identification number of the provider of the service(s);
- a diagnosis from the Physician;
- the date of service;
- an itemized bill from the provider that includes:
  - the Current Procedural Terminology (CPT) codes;
  - a description of each service and the charge for each service;
  - the date the Sickness or Injury began; and
  - 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 and address of the other insurance company(s).

Failure to provide all the information listed above may delay any reimbursement that may be due to you.

The above information should be filed with us at the address on your ID card. When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Medco Health Solutions, Inc.
P.O. Box 14711
Lexington, KY 40512

After UnitedHealthcare has processed your claim, you will receive payment for the Benefits that the Plan in which you are enrolled allows. It is your responsibility to pay the Non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

UnitedHealthcare will pay Benefits to you unless:

- the provider notifies UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider; or
- you make a written request for the Non-Network provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your provider, and not to a third party, even if your provider has assigned Benefits to that third party.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered dependent, you will receive a Health Statement in the mail. A Health Statement is a single, integrated statement that summarizes the Explanation of Benefits (EOB) information by providing detailed content on your account balances and claim activity. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for Covered Persons online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 14, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Claims
All claim forms must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by Travis County. This 12-month requirement 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.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include:

- the patient's name and identification number as shown on the ID card;

- the provider's name;
- the date(s) of medical service(s);
- the reason you believe your claim for Benefits should be paid and include facts based only on whether or not Benefits are available under the Plan in which you are enrolled, and the proposed treatment or procedure; and
- any clinical documentation or other written information to support your request for claim payment.

Please note that the decision is based only on whether or not Benefits are available under the Plan in which you are enrolled, and the proposed treatment or procedure. The decision for you to receive services is between you and your Physician.

You or your authorized representative may send a written request for an appeal to:

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

For requests for Urgent Care Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is a:

- request for Urgent Care Benefits;
- pre-service request for Benefits;
- post-service claim; or
- concurrent claim.

There are four types of claims:

- Request for Benefits for Urgent Care - a request for Benefits provided in connection with Urgent Care services for treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed to avoid complications and unnecessary suffering;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.
- Concurrent Care – a request to extend an on-going course of treatment was previously approved for a specific period of time or number of treatments beyond that which was previously approved. (The way this request is processed depends on whether the treatment extension is an Urgent Care request or involves a non-urgent circumstance.)

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from Travis County through its Risk and Benefit Manager at its Human Resources Management Department within 60 days after receipt of the first level appeal determination. Travis County must notify you of the appeal determination within 15 days after receiving the completed appeal for a pre-service denial and 30 days after receiving the completed post-service appeal.

The appeal must be in writing and must include at least the following information and authorizations:

- your name and identification number as shown on the ID card;
- the name of the patient whose care is being appealed;
- the name and address of the medical providers involved;
- The reason you believe your claim for Benefits should be paid and include facts based only on whether or not Benefits are available under the Plan in which you are enrolled, and the proposed treatment or procedure;
- copies of all documents previously submitted for consideration to UnitedHealthcare for its review of its decision not to approve coverage for Health Services;
- an authorization for release of medical information to the Risk and Benefit Manager, the Appeals Committee panel hearing the appeal, and the County Attorney advising the panel; and
- an authorization for review and discussion of medical information to the Risk and Benefit Manager, the Appeals Committee panel hearing the appeal, and the County Attorney advising the panel as necessary to hear and determine the appeal.

The appeal should be enclosed in a sealed envelope or a sealed box and marked "Confidential Appeal" to notify Travis County that the contents should be kept confidential. If the appeal is marked "Confidential Appeal", it will only be opened by the Risk and Benefit Manager or the Director of the Human Resources Management Department.

Within five businesses days after receipt of an appeal, the Risk and Benefit Manager will establish an Appeal Committee panel of three members from the Appeals Committee appointed by the Commissioners Court. This panel will include at least one licensed medical

practitioner with expertise that is appropriate to the medical issue being appealed and the Risk and Benefit Manager or his representative. The Risk and Benefit Manager will set the time, location, and agenda for the Appeals Committee hearing and post Open Meetings notices.

The panel will review the information you submitted and hold a hearing to make a decision about the appeal. A representative of the County Attorney may also attend the appeal hearing but cannot vote on the appeal.

The Appeals Committee panel must issue a written decision with reasons for its decision within 7 business days after the Risk and Benefit Manager receives the complete written appeal. Written decisions of a panel of the Appeal Committee will not include any information that identifies who you are, like your name or social security number. This 7 business days does not begin until you have provided all of the required information.

Meetings of an Appeals Committee panel must comply with the Texas Open Meetings Act. Notice of meetings must be posted and the panel may go into closed session to discuss the appeal.

You may present information to the Appeals Committee panel at the hearing in both open and closed session. If you present the information in writing, you can preserve the confidentiality of your identity. If you choose to present information orally in person in open session at the hearing of the panel, the fact that you presented the information in this manner acts as a release of the medical information presented to everyone at the open session of the hearing and a waiver of any right you would otherwise have to confidentiality of your identity.

You will be allowed to be present in the closed session unless the panel needs to receive legal advice about the appeal. You will not be allowed to be present for any legal advice that is provided in closed session.

All written information you provide in the appeal, all oral information you provide in closed session at the hearings, and all discussions about any appeal by the Appeal Committee panel must be kept confidential.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. Travis County will review all claims in accordance with the rules established by the U.S. Department of Labor.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Request for Urgent Care Benefits	
You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare at the toll-free number on your ID card as soon as possible to appeal a Request for Urgent Care Benefits.	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**24 hours** of receipt of your request
You must then provide a completed request for Benefits to UnitedHealthcare within:	**48 hours** after receiving notice of the additional information required
UnitedHealthcare must notify you of the benefit determination within:	**72 hours** after receiving the additional information
If UnitedHealthcare denies your request for Benefits, you must appeal a claims denial no later than:	**180 days** after receiving the initial claim denial
UnitedHealthcare must notify you of the appeal decision within:	**72 hours** after receiving the appeal

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	**5 days**
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	**15 days**
You must then provide the complete request for Benefits information to UnitedHealthcare within:	**45 days**
UnitedHealthcare must notify you of the benefit determination:	
■ If the initial request for Benefits is complete, within:	**15 days** after receiving the complete request for Benefits

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
■ If the initial request for Benefits is incomplete, within:	**15 days** after receiving the additional information to complete the request for Benefits
You must appeal an adverse Benefit determination no later than:	**180 days** after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving an adverse benefit determination on the first level appeal
Travis County must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal**

**Travis County may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond its control.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days** after receipt of your claim
You must then provide completed claim information to UnitedHealthcare within:	**45 days** after notice of the incomplete information
UnitedHealthcare must notify you of the benefit determination:	
■ If the initial claim is complete, within:	**30 days** after receipt of the complete claim
■ If the initial claim is incomplete, within:	**30 days** after receiving the completed claim
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit

Post-Service Claims	
Type of Claim or Appeal	**Timing**
	determination
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
If you wish to appeal, you must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving an adverse decision on the first level appeal
Travis County must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal**

[2]**Travis County may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond its control.

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 a request for Urgent Care Benefits as defined above, UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours after receipt of your request.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

External Review Program

If, after exhausting your internal appeals, you are not satisfied with the final determination, you may participate in the external review program. This program only applies if the adverse benefit determination is based on:

- clinical reasons;
- exclusions for Experimental or Investigational Services or Unproven Services; or
- as otherwise required by applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you after you exhaust the appeals processes identified above and you receive an unfavorable decision, or if Travis County fails to respond to your appeal within the time lines stated below.

You, your treating Physician, or an authorized designated representative may request an independent review of the claim denial. Neither you nor Travis County will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision.

All requests for an independent review must be made within four (4) months after the date you receive the claim denial. You make the request for an independent review by contacting the toll-free number on your ID card or by sending a written request to the address on your ID card.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a Covered Health Service under the Plan. The Independent Review Organization (IRO) has been contracted by UnitedHealthcare and has no material affiliation or interest with UnitedHealthcare or Travis County. UnitedHealthcare will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UnitedHealthcare's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- all relevant medical records;
- all other documents relied upon by Travis County in making a decision on the case; and
- all other information or evidence that you or your Physician has already submitted to Travis County.

If there is any information or evidence you or your Physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an independent review, and UnitedHealthcare will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if you meet all the criteria for independent review and the Physician certifies that the requested service or procedure would be significantly less effective if not promptly initiated.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide you and Travis County with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide Benefits for the service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the service or procedure.

The *Departments of Health and Human Services*, *Labor* and *Treasury (Departments)* will establish a Federal external review process. Where applicable, once the process has been established by the *Departments*, you will be provided with additional information about that process.

Contact UnitedHealthcare at the telephone number shown on your ID card for more information on the Federal external review program.

Limitation of Action

You cannot bring any legal action against Travis County or UnitedHealthcare to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against Travis County or UnitedHealthcare, you must do so within three years after the end of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against Travis County or UnitedHealthcare.

You cannot bring any legal action against Travis County or UnitedHealthcare for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against Travis County or UnitedHealthcare you must do so within three years after the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against Travis County or UnitedHealthcare.

SECTION 10 - COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans;
- How coverage is affected if you become eligible for Medicare; and
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any of the following:

- another employer sponsored health benefits plan;
- a medical component of a group long-term care plan, such as skilled nursing care;
- no-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The primary plan pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

Note: The Coordination of Benefits provision described here does not apply to covered Prescription Drugs as described in Section 15, *Prescription Drugs*. Benefits for Prescription Drugs will not be coordinated with those of any other health coverage plan.

Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;
- your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that

pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:

- the parents are married or living together whether or not they have ever been married and not legally separated; or
- a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;

- if two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - the parent with custody of the child; then
  - the Spouse of the parent with custody of the child; then
  - the parent not having custody of the child; then
  - the Spouse of the parent not having custody of the child;

- plans for active employees pay before plans covering laid-off or employees who retire while covered under the Plan;
- the plan that has covered the individual claimant the longest will pay first. The expenses must be covered in part under at least one of the plans; and
- finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan – Examples

1) Let's say you and your Spouse or Domestic Partner both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as a Member under this Plan, and as a dependent under your Spouse's or Domestic Partner's plan, this Plan will pay Benefits for the Physician's office visit first.

2) Again, let's say you and your Spouse or Domestic Partner both have family medical coverage through your respective employers. You take your dependent child to see a Physician. This Plan will look at your birthday and your Spouse's or Domestic Partner birthday to determine which plan pays first. If you were born on June 11 and your Spouse or Domestic Partner was born on May 30, your Spouse's or Domestic Partner's plan will pay first.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Plan determines the amount it would have paid had it been the only plan involved.
- the Plan pays the entire difference between the allowable expense and the amount paid by the primary plan – as long as this amount is not more than the Plan would have paid had it been the only plan involved.

The maximum combined payment you may receive from all plans cannot exceed 100% of the total allowable expense. For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

Determining the Allowable Expense When This Plan is Secondary

When this Plan is secondary, the allowable expense is the primary plan's Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you do not elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- employees with active current employment status at Travis County age 65 or older and their Spouses age 65 or older; and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

Medicare Cross-Over Program

The Plan offers a Medicare Cross-over Program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. If you enroll for this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses.

Once the Medicare Part A and Part B and DME carrier[s] have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to UnitedHealthcare to process the balance of your claim under the provisions of this Plan.

To participate in the Medicare Cross-over Program, you must complete a separate form authorizing this service and submit it to UnitedHealthcare. Your Spouse can also enroll for this program, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

You can verify that the automated cross-over is in place by determining whether your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier. Until this message appears, you must continue to file secondary claims with UnitedHealthcare.

This cross-over process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

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 Plan and other plans. Travis County's Benefits Manager may get the facts needed from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

Travis County's Benefits Manager does not need to tell or get the consent of any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that UnitedHealthcare should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the County may recover the amount in the form of salary, wages, or benefits payable under any County-sponsored benefit plans, including this Plan. Travis

County also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount by legal action, if necessary.

Refund of Overpayments

If Travis County pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid must make a refund to Travis County if:

- all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;
- all or some of the payment Travis County made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

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

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

SECTION 11 - SUBROGATION AND REIMBURSEMENT

What this section includes:
- How your Benefits are impacted if you suffer a Sickness or Injury caused by a third party.

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

Right of Recovery

The Plan has the right to recover benefits it has paid on any Covered Person's behalf that were:

- made in error;
- made due to a mistake in fact;
- advanced before you have met the calendar year Deductible; or
- advanced before you have met the Out-of-Pocket Maximum for the calendar year.

Benefits paid because any Covered Person's misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your dependent before you have met the Deductible and/or the Out-of-Pocket Maximum for the calendar year, the Plan will send you a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- submitting a reminder letter to you that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you to discuss any outstanding balance owed to the Plan.

Right to Subrogation

The right to subrogation means the Plan has the right to pursue 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. The Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any

type, for 100 percent of any services and Benefits the Plan has paid on your behalf relating to any Sickness or Injury caused by any third party.

Right to Reimbursement

The right to reimbursement means that if a third party causes a Sickness or Injury for which you receive a settlement, judgment, or other recovery 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;
- Travis County in workers' compensation cases; or
- 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; or
  - 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. Any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not 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. A "collateral source" rule shall not 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;
  - 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.
- 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.
- In case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs.
- 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 about the interpretation of the language stated herein.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end; and
- How to continue coverage after it ends.

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, Travis County will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Your coverage under the Plan will end on the earliest of:

- the last day of the month in which your employment with Travis County ends;
- the last day of the month in which you retire under the Plan, unless you continue your coverage as a retired person.
- the date the Plan ends;
- the last day of the month in which you stop making the required contributions unless otherwise required by law;
- the last day of the month in which you are no longer eligible.
- the last day of the month in which UnitedHealthcare receives written notice from Travis County to end your coverage, or the date requested in the notice, if later.

Coverage for your eligible dependents will end on the earliest of:

- the last day of the month in which your coverage ends;
- the last day of the month in which you stop making the required contributions;
- the last day of the month in which UnitedHealthcare receives written notice from Travis County to end your coverage, or the date requested in the notice, if later; or
- the last day of the month in which your dependents no longer qualify as eligible dependents under this Plan.

Other Events Ending Your Coverage

The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if:

- you commit an act, practice, or omission that constitutes 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; or

- you commit an act of physical or verbal abuse that imposes a threat to Travis County's staff, UnitedHealthcare's staff, a provider or another Covered Person.

Note: Travis County has the right to demand that you pay back Benefits Travis County paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Child

If an unmarried enrolled Child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will cover the Child, as long as:

- the Child is incapacitated and dependent, that is, unable to be self-supporting due to a mental or physical condition or disability;
- the Child depends mainly on you for support;
- initially you provide Travis County proof of the Child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age; and
- periodically after that you provide proof, upon Travis County's request, that the Child continues to meet these conditions.

The proof might include medical examinations at Travis County's expense. However, you will not be asked for this information more than once a year. If you do not supply this proof within 31 days, the Plan will no longer pay Benefits for that Child.

As long as the enrolled child is incapacitated and dependent upon you, coverage will continue unless coverage is otherwise terminated in accordance with the terms of the Plan.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined under *COBRA* in Section 14, *Glossary*.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Travis County's Benefits Manager to determine if Travis County is subject to the provisions of COBRA.

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 Travis County's Benefit Administrator if you have questions about your right to continue coverage.

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 were covered under the Plan on the day before a qualifying event:

- a Member;
- a Member's child, including with respect to the Member's children, a child born to or placed for adoption with the Member during a period of continuation coverage under federal law; or
- a Member's Spouse or former Spouse.

Note: A Domestic Partner, a Domestic Partner's child and a Sponsored Dependent are not Qualified Beneficiaries under COBRA.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for Qualified Beneficiaries, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Member's Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your Qualifying Beneficiaries become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Member's child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
Travis County files for bankruptcy under Title 11, United States Code.[2]	36 months	36 months[3]	36 months[3]

Footnotes appear on the following page.

Footnotes:

[1]Subject to the following conditions:
(i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, 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 over the original 18 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.

[2]This is a qualifying event for any retired Member and his or her enrolled Spouse or child if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

[3]From the date of the Member's death if the Member dies during the continuation coverage.

How Your Medicare Eligibility Affects COBRA Coverage for Your Qualified Beneficiaries

The table below outlines how your dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Coverage for Your Qualified Beneficiaries Up To:
You become entitled to Medicare and do not experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of eligibility for coverage for your Spouse and Member's Child under the Plan	36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Member and Travis County costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will only inform a provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began in response to a request from that provider.

While you are a Member in the medical Plan under COBRA, you have the right to change your coverage election:

- during Open Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2*, Introduction*.

Notification Requirements

If your covered Spouse or Member's child(ren) lose coverage due to divorce, legal separation, or loss of dependent status, you or your Spouse or Member's child(ren) must notify the Human Resources Management Department within 60 days of the latest of:

- the date of the divorce, legal separation or loss of eligibility of an enrolled Spouse or Member's child(ren)'s as an enrolled dependent;
- the date your enrolled Spouse or Member's child(ren) would lose coverage under the Plan; or
- the date on which you or your enrolled Spouse or Member's child(ren) are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Spouse or Member's child(ren) must also notify the Travis County's Risk and Benefit Manager when a qualifying event occurs that will extend continuation coverage.

If you or your Spouse or Member's child(ren) fail to notify the Travis County's Benefit Administrator of these events within the 60 day period, the Travis County's Benefit Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Travis County's Benefit Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Travis County's Benefit Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide the Human Resources Management Department with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Travis County's Benefit Administrator at the address stated in Section 16, *Important Administrative Information*. The contents of the notice must be such that the Travis County's Benefit Manager is able to determine the covered Employee and Qualified Beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Members who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Members are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Member qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Travis County's Benefit Administrator for additional information. The Member must contact the Travis County's Benefit Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Member will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

When COBRA Ends

COBRA coverage will end before the maximum continuation period shown above if:

- you or your covered Spouse or Member's child(ren) becomes covered under another group medical plan, as long as the other plan does not limit your coverage due to a preexisting condition; or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends;
- you or your covered Spouse or Member's child(ren) becomes entitled to, and enrolls in, Medicare after electing COBRA;
- the first required premium is not paid within 45 days after the date of the COBRA election;

- any other monthly premium is not paid within 30 days of its due date;
- the entire Plan ends; or
- coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: 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 in this section, whichever is earlier.

Uniformed Services Employment and Reemployment Rights Act

A Member who is absent from employment for more than 30 days due service in the Uniformed Services may elect to continue Plan coverage for the Member and the Member's dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Members may elect to continue coverage under the Plan by notifying the Travis County's Benefit Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount Travis County normally pays on a Member's behalf. If a Member's Military Service is for a period of time less than 31 days, the Member may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

A Member may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Member's absence from work; or
- the day after the date on which the Member fails to apply for, or return to, a position of employment.

Regardless of whether a Member continues health coverage, if the Member returns to a position of employment, the Member's health coverage and that of the Member's eligible dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Member or the Member's eligible dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call Travis County if you have questions about your rights to continue health coverage under USERRA.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for dependent children;
- Your relationship with UnitedHealthcare and Travis County;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan; and
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Travis County's Benefit Administrator will review the order to determine if it meets the requirements for a QMCSO. If the Travis County's Benefit Administrator determines that the order does meet the requirements for a QMCSO, your child will be enrolled in the Plan as your dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Travis County's Benefit Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and Travis County

To make choices about your health care coverage and treatment, Travis County believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit Plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- Travis County and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions;

- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD); and
- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

Travis County and UnitedHealthcare may use individually identifiable information about you to identify procedures, products or services that you may find valuable.

Travis County and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. Travis County and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between Travis County, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not Travis County's agents or employees, and they are not agents or employees of UnitedHealthcare. Travis County and any of its employees are not agents or employees of Network providers, and UnitedHealthcare and any of its employees are not agents or employees of Network providers. Travis County and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. Travis County and UnitedHealthcare are not liable for any act or omission of any provider.

Travis County and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, Travis County and UnitedHealthcare arrange for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

UnitedHealthcare is not considered to be an employer of Travis County or its employees for any purpose with respect to the administration or provision of benefits under this Plan.

Travis County is solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- the payment of Benefits; and
- 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. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own provider;
- are responsible for paying, directly to your provider, any amount identified as a Member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your provider, the cost of any service that is not a Covered Health Service;
- 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); and
- must decide with your provider what care you should receive.

Interpretation of Benefits

Travis County and UnitedHealthcare have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

Travis County and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

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

Information and Records

Travis County and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. Travis County and UnitedHealthcare may request additional information from you to decide your claim for Benefits. Travis County and UnitedHealthcare will keep this information confidential. Travis County and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish Travis County and UnitedHealthcare with all information or copies of records relating to the services provided to you. Travis County and UnitedHealthcare 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 Member's enrollment form. Travis County and UnitedHealthcare agree that such information and records will be considered confidential.

Travis County and UnitedHealthcare 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 Travis County is required to do by law or regulation. During and after the termination of the Plan, Travis County and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

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

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

In some cases, Travis County and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as Travis County.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare 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; or
- a practice called capitation which occurs when a group of Network providers receives a monthly payment from UnitedHealthcare 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.

If you have any questions about financial incentives you may contact the telephone number on your ID card. You can ask 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. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but Travis County recommends that you discuss

participating in these programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

Travis County and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. Travis County and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copays or Coinsurance.

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.

Future of the Plan

Although Travis County currently has no plans to discontinue the Plan, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

Travis County's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or any other reason. A Plan change may transfer Plan assets and debts to another plan or split a Plan into two or more parts. If Travis County does change or terminate a Plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred before the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Travis County decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Travis County and others as may be required by any applicable law.

Plan Document

This Summary Plan Description (SPD) is an overview of your Benefits. If there is a discrepancy between the SPD and the official plan document, the plan document governs. A copy of the plan document is available for your inspection during regular business hours in the office of Travis County's Risk and Benefit Manager. You (or your personal representative) may obtain a copy of this document by written request to Travis County's Risk and Benefit Manager, for a nominal charge.

SECTION 14 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD.

Addendum – any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments to it apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum is controlling.

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

- surgical services;
- Emergency Room Health Services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance Use Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment Facility).

Amendment – any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by Travis County or UnitedHealthcare. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

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

Benefits – Plan payments for Covered Health Services as described in this SPD, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

CHD – see Congenital Heart Disease (CHD).

COBRA – the acronym for Consolidated Omnibus Budget Reconciliation Act of 1985 which is a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

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

Congenital Heart Disease (CHD) – any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- be passed from a parent to a child (inherited);
- develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; or
- have no known cause.

Cosmetic Procedure – a procedure or service that changes or improves appearance without significantly improving physiological functioning, as determined by UnitedHealthcare. Reshaping a nose with a prominent bump is an example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in any function like breathing or smelling.

Cost-Effective – the least expensive method of treatment or equipment that performs the necessary function.

Covered Health Services – those health related services, supplies or Pharmaceutical Products, which Travis County determines to be:

- provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, Substance Use Disorders, or their symptoms;
- consistent with nationally recognized Scientific Evidence as available, and Prevailing Medical Standards and Clinical Guidelines;
- not generally considered to be provided for the convenience of the Covered Person, Physician, facility or any other person;
- described in Sections 5 and 6, Plan Highlights and Additional Coverage Details;
- provided to a Covered Person and
- not identified in Section 8, *Exclusions*.

In applying this definition, "Scientific Evidence" and "Prevailing Medical Standards and Clinical Guidelines" have the following meanings:

- "Scientific Evidence" means the results of controlled Clinical Trials (scientific studies designed to identify new health services that improve health outcomes in which two or more treatments are compared and the patient is not allowed to choose which treatment is received) or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community; and
- "Prevailing Medical Standards and Clinical Guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

UnitedHealthcare maintains clinical protocols that describe the Scientific Evidence, Prevailing Medical Standards and Clinical Guidelines supporting its determinations about

specific services. You can access these clinical protocols (as revised from time to time) on **www.myuhc.com** or by calling the number on the back of your ID card. This information is available to Physicians and other health care professionals on UnitedHealthcareOnline.

Covered Person – either the Member or an enrolled dependent only while enrolled and eligible for Benefits under the Plan as described under *Eligibility* in Section 2, *Introduction*. References to "you" and "your" throughout this SPD are references to a Covered Person.

Custodial Care – services that do not require special skills or training and that:

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Designated Facility – a facility that has entered into an agreement with UnitedHealthcare or with an organization contracting on behalf of the Plan, to provide Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area.

To be considered a Designated Facility, a facility must meet certain standards of excellence and have a proven track record of treating specific conditions as determined in accordance with UnitedHealthcare's policy guidelines for the medical condition involved.

Domestic Partner – an individual who:

- shares the same permanent residence and the common necessities of life with the Member; and
- has provided Travis County with a completed Certification of Domestic Partnership that includes the names and any required information for any unmarried eligible children of the Domestic Partner for whom coverage is sought.

A Domestic Partner or a Domestic Partner's child is not eligible for COBRA or dependent life coverage. An employee may only cover one other adult as a dependent.

Durable Medical Equipment (DME) – medical equipment that is all of the following:

- ordered or provided by a Physician for outpatient use;
- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not consumable or disposable;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;

- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

Eligible Expenses for Choice Plus Plan – charges for Covered Health Services that are provided while the Plan is in effect, determined as follows:

For:	Eligible Expenses are Based On:
Network Benefits	■ contracted rates with the provider or ■ when Covered Health Services are received from a Non-Network provider in circumstances that qualify the services to be treated as Network Benefits, the amounts billed by the provider, unless UnitedHealthcare negotiates lower rates.
Non-Network Benefits	■ negotiated rates agreed to by the Non-Network provider and either UnitedHealthcare or one of its vendors, affiliates or subcontractors, at the discretion of UnitedHealthcare; or ■ one of the following: - for Covered Health Services other than Pharmaceutical Products, selected data resources which, in the judgment of UnitedHealthcare, represent competitive fees in that geographic area (i.e maximum allowable charge); - for Covered Health Services that are Pharmaceutical Products, 100% of the amount that the *Centers for Medicare and Medicaid Services (CMS)* would have paid under the Medicare program for the drug determined by either: ♦ reference to available *CMS* schedules; or ♦ methods similar to those used by *CMS*; or ■ 80% of the billed charge; or ■ A fee schedule that UnitedHealthcare develops in accordance with UnitedHealthcare's reimbursement policy guidelines.

Eligible Expenses for Choice and CoInsured Plans – charges for Covered Health Services that are provided while the Plan is in effect, determined as follows:

For:	Eligible Expenses are Based On:
Network Providers	contracted rates with that provider
Non-Network Providers	If you receive Covered Health Services from a non-Network provider in an Emergency, Eligible Expenses are the amounts billed by the provider, unless the Claims Administrator negotiates lower rates.

For certain Covered Health Services, you are required to pay a percentage of Eligible Expenses in the form of a Copay and/or Coinsurance.

Emergency – a serious medical condition or symptom resulting from Injury, Sickness, Mental Illness, or Substance Use Disorders which:

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

Emergency Room Health Services – Covered Health Services necessary for the treatment of an Emergency.

Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time UnitedHealthcare and Travis County make a determination about 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 (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational); or
- the subject of an ongoing Clinical Trial (a scientific study designed to identify new health services that improve health outcomes in which two or more treatments are compared and the patient is not allowed to choose which treatment is received) 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.

Exceptions

If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), and other Covered Health Services have been considered and would not be effective in treating it, UnitedHealthcare and Travis County may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition for that Covered Person only. Prior to such consideration, UnitedHealthcare and Travis County must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) – a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Annual Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and,
- if not covered, the reason(s) why the service or supply was not covered by the Plan.

Hospital – an institution, operated as required by law, which is all of the following:

- primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance use disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and
- has 24 hour nursing services;
- is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations;
- is approved by Medicare as a Hospital;
- is operated continuously with organized facilities for operative surgery on the premises;
- not primarily a place for rest, Custodial Care or care of the aged; and
- not a Skilled Nursing Facility, convalescent home or similar institution.

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

Inpatient Rehabilitation Facility –a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility that provides 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.

Medicaid – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medicare – Parts A, B, C or D, as applicable, 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.

Member –To be eligible for coverage under the Plan, a Member must reside within the United States.

For:	A Member is an enrolled person who:
Plans for Employees	is a regular employee of Travis County who is scheduled to work at least 20 hours per week.
Plans for Retirees	a retiree who retires while covered under the Plan and elects to continue coverage

Member's Child - a natural child or stepchild or legally adopted child of the Member or the Member's Spouse. The term Member's Child also includes a child for whom legal guardianship has been awarded to the Member or the Member's Spouse.

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 Administrator – the organization or individual designated by Travis County who provides or arranges Mental Health and Substance Use Disorder Services under the Plan.

Mental Illness – mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are specifically listed in Section 8, *Exclusions*.

Network – when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with UnitedHealthcare or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. UnitedHealthcare's affiliates are those entities affiliated with UnitedHealthcare through common ownership or control with UnitedHealthcare or with UnitedHealthcare's ultimate corporate parent, including direct and indirect subsidiaries.

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

Network Benefits - Benefits that are paid for Covered Health Services provided by Network provider. Refer to Section 5, *Plan Highlights* for details about how Network Benefits apply.

Non-Network Benefits - Benefits that are paid for Covered Health Services provided by Non-Network providers unless special circumstances apply. Refer to Section 5, *Plan Highlights* for details about how Non-Network Benefits apply. This definition does not apply to Choice or CoInsured Plans.

Open Enrollment – the period of time, determined by Travis County, during which eligible Members may enroll themselves and their eligible dependents under the Plan.

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.

Personal Health Support – programs provided by UnitedHealthcare that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered dependents. Refer to Section 4, *Personal Health Support* for details about this program.

Personal Health Support Nurse – the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition who calls you to assess your progress and provide you with information and education related to your condition and its treatment. Refer to Section 4, *Personal Health Support* for details about this program.

Pharmaceutical Products – FDA-approved prescription pharmaceutical products administered on an outpatient basis in connection with a Covered Health Service which, due to their characteristics (as determined by UnitedHealthcare), must be administered by or the administration of which must be directly supervised by a Physician or other licensed or certified health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

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 a provider is described as a Physician does not mean that Benefits for all services from that provider are available to you under the Plan.

Plan(s) – The Travis County Employee Health Benefit Fund Plan. The Plan options are Choice Plus, Choice or CoInsured. When the SPD says "Plan" without reference to any option it means the information applies to all options. When the SPD references one or more options (i.e. Choice Plus Plan, Choice or CoInsured Plans) it means the information applies on to the referenced option(s).

Plan Sponsor – Travis County.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with carrying a developing offspring in your body.

Primary Care Provider –For Covered Health Services, a Physician who has a majority of his or her practice in general pediatrics, allergy and immunology, internal medicine, obstetrics/gynecology, family practice or general medicine. For Mental Health Services and Substance Use Disorder Services, a person who is providing services in licensed professional counseling (Masters or Ph.D. level), licensed clinical social work (Masters or Ph.D. level), or psychology (Masters or Ph.D. level) is considered on the same basis as a Primary Care Provider for the provision of all services. Any Doctor of Chiropractics, "DC", who is properly licensed and qualified by law to practice chiropractic medicine.

Private Duty Nursing – nursing care that is provided by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.) to a Covered Person on a one-to-one basis by licensed nurses in a home setting when the Skilled Care can be provided by a program or organization authorized by law to provide health care services in the home on a per visit basis for a specific purpose.

Reconstructive Procedure – a procedure performed to address a physical impairment where the expected outcome is restored or improved physiologic function for an organ or body part either to treat a medical condition or to improve or restore that physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

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;
- it provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Administrator;
- 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.

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

Shared Savings Program - the Shared Savings Program provides access to discounts from Non-Network Physicians who participate in that program. UnitedHealthcare will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. While UnitedHealthcare might negotiate lower Eligible Expenses for Non-Network Benefits, the Coinsurance will stay the same as described in Section 5, *Plan Highlights*.

UnitedHealthcare does not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, in benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by Non-Network providers are payable at Network Benefit levels, as in the case of Emergency Room Health Services). When UnitedHealthcare uses the Shared Savings Program to pay a claim, the patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.

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.

Skilled Care – skilled nursing, teaching, and rehabilitation services when:

- they are 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;
- a Physician orders them;
- they require clinical training in order to be delivered safely and effectively; and

- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility – a nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

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 physician who has a majority of his practice in psychiatry is considered a Specialist Physician.

Spinal Treatment – the therapeutic application of chiropractic and/or manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Spouse – an individual to whom you are married in a formal ceremony or at common law.

Sponsored Dependent - A person who:

- currently shares a permanent residence, including shared expenses and responsibilities for the common necessaries of life, and has been living with the Member for at least six consecutive months;
- is over 18 years of age;
- is not married to anyone;
- is not in the active service in the armed forces,
- is related to the Member within three degrees of blood (for example, parent, child, grandparent, grandchild, great grandparent, great grandchild, sibling, niece, nephew, aunt, uncle); and
- has provided the Plan Sponsor with a Certification of Sponsored dependent by the Member confirming that the above qualities truly apply to the relationship between the Member and the person and stating the names and other required information for the person's children for whom coverage is sought.

A Sponsored Dependent is not eligible for COBRA. An employee may only cover one other adult as a dependent.

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.

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:

- 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; or
- 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 – health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies are studies in which 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.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com**.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), and other Covered Health Services have been considered and would not be effective in treating it, UnitedHealthcare and Travis County may, at their discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition for that Covered Person only. Before such a consideration, UnitedHealthcare and Travis County must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.
- UnitedHealthcare and Travis County may, in their discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:

- If the service is one that requires review by the *U.S. Food and Drug Administration* (FDA), it must be FDA-approved.
- It must be performed by a Physician and in a facility with demonstrated experience and expertise.
- The Covered Person must consent to the procedure acknowledging that UnitedHealthcare and Travis County do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
- At least two studies must be available in published peer-reviewed medical literature that would allow UnitedHealthcare and Travis County to conclude that the service is promising but unproven.
- The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare and Travis County's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care – treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Urgent Care Center – a facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- do not require an appointment;
- are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends; and
- provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

SECTION 15 - PRESCRIPTION DRUGS (10/1/2010 – 9/30/2011)

What this section includes:

- Benefits available for Prescription Drugs;
- How to utilize the retail and mail order service for obtaining Prescription Drugs;
- Any benefit limitations and exclusions that exist for Prescription Drugs; and
- Definitions of terms used throughout this section related to the Prescription Drug Plan.

Prescription Drug Coverage Highlights

The table below provides an overview of the Plan's Prescription Drug coverage. It includes Copay amounts that apply when you have a prescription filled at a Pharmacy. For detailed descriptions of your Benefits, refer to *Retail* and *Mail Order* in this section.

The Benefits described within this section apply to all Plans in the SPD.

You are responsible for paying any amounts due to the pharmacy at the time you receive your prescription drugs.

Covered Health Services	Percentage of Prescription Drug Cost Payable by the Plan:	Percentage of Predominant Reimbursement Rate Payable by the Plan:
	Network	**Non-Network**
Retail - up to a 31-day supply	100% after you pay a:	
■ Generic (tier-1)	$10 Copay	
■ Brand-name when no generic is available (tier-2)	$30 Copay	
■ Brand-name when generic is available (tier-3)	$50 Copay	
Mail order - up to a 90-day supply	100% after you pay a:	
■ Generic (tier-1)	$20 Copay	
■ Brand-name when no generic is available (tier-2)	$60 Copay	
■ Brand-name when generic is available (tier-3)	$100 Copay	

Note: The Coordination of Benefits provision described in Section 10, *Coordination of Benefits (COB)* does not apply to covered Prescription Drugs as described in this section. Benefits for Prescription Drugs will not be coordinated with those of any other health coverage plan.

Identification Card (ID Card) – Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by UnitedHealthcare.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

Benefit Levels

Benefits are available for outpatient Prescription Drugs that are considered Covered Health Services.

The Plan pays Benefits at different levels for tier-1, tier-2 and tier-3 Prescription Drugs. All Prescription Drugs covered by the Plan are categorized into these three tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug, depending on its tier assignment. Since the PDL may change periodically, you can visit **www.myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card for the most current information.

Each tier is assigned a Copay, which is the amount you pay when you visit the pharmacy or order your medications through mail order. Your Copay will also depend on whether or not you visit the pharmacy or use the mail order service - see the table shown at the beginning of this section for further details. Here's how the tier system works:

- Tier-1 is your lowest Copay option. For the lowest out-of-pocket expense, you should consider tier-1 drugs if you and your Physician decide they are appropriate for your treatment.
- Tier-2 is your middle Copay option. Consider a tier-2 drug if no tier-1 drug is available to treat your condition.
- Tier-3 is your highest Copay option. The drugs in tier-3 are usually more costly. Usually there are alternatives available in tier-1 or tier-2.

For Prescription Drugs at a retail Network Pharmacy or from a mail order Network Pharmacy, you are responsible for paying the lowest of:

- the applicable Copay;
- the Network Pharmacy's Usual and Customary Charge for the Prescription Drug; or
- the Prescription Drug Cost that UnitedHealthcare agreed to pay the Network Pharmacy.

Retail

The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting

UnitedHealthcare at the toll-free number on your ID card or by logging onto **www.myuhc.com**.

To obtain your prescription from a retail pharmacy, simply present your ID card and pay the Copay. The Plan pays Benefits for certain covered Prescription Drugs:

- as written by a Physician;
- up to a consecutive 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on quantity limits;
- when a Prescription Drug is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copay that applies will reflect the number of days dispensed; and
- a one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Copay for each cycle supplied.

Note: Pharmacy Benefits apply only if your prescription is for a Covered Health Service or if prescribed by a Physician for dental services. If the Pharmacy Benefits apply to Experimental or Investigational, or Unproven Services, you are responsible for paying 100% of the cost.

Mail Order

The mail order service may allow you to purchase up to a 90-day supply of a covered maintenance drug through the mail. Maintenance drugs help in the treatment of chronic illnesses, such as heart conditions, allergies, high blood pressure, and arthritis.

To use the mail order service, all you need to do is complete a patient profile and enclose your prescription order or refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received. If you need a patient profile form, or if you have any questions, you can reach UnitedHealthcare at the toll-free number on your ID card.

The Plan pays mail order Benefits for certain covered Prescription Drugs:

- as written by a Physician; and
- up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on quantity limits.

Note: To maximize your benefit, ask your Physician to write your prescription order or refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copay for any prescription order or refill if you use the mail order service, regardless of the number of days' supply that is written on the order or refill. Be sure your Physician writes your mail order or refill for a 90-day supply, not a 30-day supply with three refills.

Want to lower your out-of-pocket Prescription Drug costs?
Consider Generic Prescription Drug Products, if you and your Physician decide they are appropriate.

Assigning Prescription Drugs to the PDL

UnitedHealthcare's Prescription Drug List (PDL) Management Committee makes the final approval of Prescription Drug placement in tiers. In its evaluation of each Prescription Drug, the PDL Management Committee takes into account a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include:

- evaluations of the therapeutic value;
- relative safety and efficacy; and
- whether quantity limits or notification requirements should apply.

Economic factors may include:

- the acquisition cost of the Prescription Drug; and
- available rebates and assessments on the cost effectiveness of the Prescription Drug.

Some Prescription Drugs are more cost effective for specific indications as compared to others, therefore, a Prescription Drug may be listed on multiple tiers according to the indication for which the Prescription Drug was prescribed.

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

The PDL Management Committee may periodically change the placement of a Prescription Drug among the tiers. These changes will not occur more than six times per calendar year and may occur without prior notice to you.

Prescription Drug, Prescription Drug List (PDL), and Prescription Drug List (PDL) Management Committee are defined at the end of this section.

Notification Requirements

Before certain Prescription Drugs are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to notify UnitedHealthcare. UnitedHealthcare will determine if the Prescription Drug is:

- a Covered Health Service as defined by the Plan; and
- not Experimental or Investigational or Unproven, as defined in Section 14, *Glossary*.

Network Pharmacy Notification

When Prescription Drugs are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying UnitedHealthcare.

Non-Network Pharmacy Notification

When Prescription Drugs are dispensed at a Non-Network Pharmacy, you or your Physician are responsible for notifying UnitedHealthcare.

If UnitedHealthcare is not notified before the Prescription Drug is dispensed, you may pay more for that Prescription Drug order or refill. You will be required to pay for the Prescription Drug at the time of purchase. The contracted pharmacy reimbursement rates (the Prescription Drug Cost) will not be available to you at a Non-Network Pharmacy. If UnitedHealthcare is not notified before you purchase the Prescription Drug, you can request reimbursement after you receive the Prescription Drug - see Section 9, *Claims Procedures*, for information on how to file a claim.

When you submit a claim on this basis, you may pay more because you did not notify UnitedHealthcare before the Prescription Drug was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost (for Prescription Drugs from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drugs from a Non-Network Pharmacy), less the required Copayment and/or Coinsurance and any Deductible that applies.

To determine if a Prescription Drug requires notification, either visit **www.myuhc.com** or call the toll-free number on your ID card. The Prescription Drugs requiring notification are subject to UnitedHealthcare's periodic review and modification.

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

Prescription Drug Benefit Claims

For Prescription Drug claims procedures, please refer to Section 9, *Claims Procedures*.

Limitation on Selection of Pharmacies

If UnitedHealthcare determines that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, you may be required to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date UnitedHealthcare notifies you, UnitedHealthcare will select a single Network Pharmacy for you.

Quantity limits

Some Prescription Drugs are subject to quantity limits that may restrict the amount dispensed per prescription order or refill. To determine if a Prescription Drug has been assigned a maximum quantity level for dispensing, either visit **www.myuhc.com** or call the toll-free number on your ID card. Whether or not a Prescription Drug has a quantity limit is subject to UnitedHealthcare's periodic review and modification.

Note: Some products are subject to additional quantity limits based on criteria that Travis County and UnitedHealthcare have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per prescription order or refill and/or the amount dispensed per month's supply.

If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug becomes available as a Generic drug, the tier placement of the Brand-name Drug may change. As a result, your Copay may change.

Special Programs

Travis County and UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced benefit based on your actions such as adherence/compliance to medication regimens. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on the back of your ID card.

Rebates and Other Discounts

UnitedHealthcare and Travis County may, at times, receive rebates from pharmaceutical companies for certain drugs on the PDL. UnitedHealthcare does not pass these rebates and other discounts on to you nor does UnitedHealthcare take them into account when determining your Copays. All rebates, less an administrative fee paid to UnitedHealthcare, are retained in the Travis County Health Benefit Fund.

UnitedHealthcare and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this Prescription Drug section. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Prescription Drug section. UnitedHealthcare is not required to pass on to you, and does not pass on to you, such amounts.

Coupons, Incentives and Other Communications

UnitedHealthcare may send mailings to you or your Physician that communicate a variety of messages, including information about Prescription Drugs. These mailings may contain coupons or offers from pharmaceutical manufacturers that allow you to purchase the described Prescription Drug at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription order or refill is appropriate for your medical condition.

Exclusions - What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed under Section 8, *Exclusions* also apply to this section, except that any preexisting condition exclusion in Section 8, *Exclusions* is not applicable to this section. In addition, the following exclusions apply.

Medications that are:

1. dispensed in amounts that are in excess of the quantity limit;

2. dispensed outside of the United States, except in an Emergency;

3. prescribed, dispensed or intended for use during an Inpatient Stay;

4. used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless UnitedHealthcare and Travis County have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in Section 14, *Glossary*;

5. any Prescription Drug for which payment or benefits are provided from the local, state or federal government whether or not payment or benefits are received, except as otherwise provided by law;

6. for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received;

7. prescribed for appetite suppression, and other weight loss products;

8. Pharmaceutical Products for which Benefits are provided in the medical (not in Section 15, *Prescription Drugs*) portion of the Plan;

9. Durable Medical Equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered);

10. vitamins, except for the following which require a prescription:

    - prenatal vitamins;
    - vitamins with fluoride; and
    - single entity vitamins.

11. unit dose packaging of Prescription Drugs;

12. used for cosmetic purposes;

13. Prescription Drugs, including new Prescription Drugs or new dosage forms, that Travis County determines do not meet the definition of a Covered Health Service;

14. Prescription Drug as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed;

15. prescribed to treat infertility;

16. compounded drugs that do not contain at least one ingredient that requires a prescription order or refill and has been approved by the U.S. Food and Drug Administration; compounded drugs that are available as a similar commercially available Prescription Drug; (compounded drugs that contain at least one ingredient that requires a prescription order or refill are assigned to Tier-3;)

17. available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless Travis County has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a prescription order or refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that Travis County has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and Travis County may decide at any time to reinstate Benefits for a Prescription Drug that was previously excluded under this provision;

18. new drugs and/or new dosages, until they are reviewed and assigned to a tier by the PDL Management Committee;

19. growth hormone for children with familial short stature based on heredity and not caused by a diagnosed medical condition;

20. oral non-sedating antihistamines or a combination of antihistamines and decongestants;

21. Prescription Drugs that contain (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug;

22. Prescription Drugs that contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug; and

23. typically administered by a qualified provider or licensed health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception;

Glossary - Prescription Drugs

Brand-name - a Prescription Drug that is either:

- manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- identified by UnitedHealthcare as a Brand-name Drug based on available data resources including, but not limited to, First DataBank or Medi-Span that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by UnitedHealthcare.

Generic - a Prescription Drug that is either:

- chemically equivalent to a Brand-name drug; or
- identified by UnitedHealthcare as a Generic Drug based on available data resources, including, but not limited to, First DataBank or Medi-Span that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by UnitedHealthcare.

Network Pharmacy - a retail or mail order pharmacy that has:

- entered into an agreement with UnitedHealthcare to dispense Prescription Drugs to Covered Persons;
- agreed to accept specified reimbursement rates for Prescription Drugs; and
- been designated by UnitedHealthcare as a Network Pharmacy.

PDL - see Prescription Drug List (PDL).

PDL Management Committee - see Prescription Drug List (PDL) Management Committee.

Predominant Reimbursement Rate – the amount the Plan will pay to reimburse you for a Prescription Drug Product that is dispensed at a Non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug dispensed at a Non-Network Pharmacy includes a dispensing fee and any applicable sales tax. UnitedHealthcare calculates the Predominant Reimbursement Rate using its Prescription Drug Cost that applies for that particular Prescription Drug at most Network Pharmacies.

Prescription Drug - a medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, only be dispensed using a prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of this Plan, Prescription Drugs include:

- inhalers (with spacers);
- insulin;
- the following diabetic supplies:
  - standard insulin syringes with needles;
  - blood testing strips - glucose;
  - urine testing strips - glucose;
  - ketone testing strips and tablets;
  - lancets and lancet devices;
  - insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets; and
  - glucose monitors.

Prescription Drug Cost – the rate UnitedHealthcare has agreed to pay its Network Pharmacies, including a dispensing fee and any applicable sales tax, for a Prescription Drug dispensed at a Network Pharmacy.

Prescription Drug List (PDL) - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration*. This list is subject to periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug has been assigned by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto **www.myuhc.com**.

Prescription Drug List (PDL) Management Committee - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

Therapeutically Equivalent – when Prescription Drugs can be expected to produce essentially the same therapeutic outcome and toxicity.

Usual and Customary Charge – the usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

SECTION 16 - IMPORTANT ADMINISTRATIVE INFORMATION

What this section includes:
- Plan administrative information.

This section includes information on the administration of the medical Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Additional Plan Description

Claims Administrator: The claims administrator is the company which provides certain administrative services for the Plan Benefits described in this Summary Plan Description. That company is UnitedHealthcare (also known as UnitedHealthcare Insurance Company) and its affiliates.

UnitedHealthcare Insurance Company
Attn: Claims
185 Asylum Street
Hartford, CT 06103-3408

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

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

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

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

UnitedHealthcare generally allows the designation of a Primary Care Provider. You have the right to designate any Primary Care Provider who participates in UnitedHealthcare's network and who is available to accept you or your family members. For information on how to select a Primary Care Provider, and for a list of the participating Primary Care Providers, contact UnitedHealthcare at the number on the back of your ID card.

For children, you may designate a pediatrician as the Primary Care Provider.

You do not need prior authorization from UnitedHealthcare or from any other person (including a Primary Care Provider) to obtain access to obstetrical or gynecological care from a health care professional in UnitedHealthcare's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact UnitedHealthcare at the number on the back of your ID card.

ATTACHMENT II - PROTECTED HEALTH INFORMATION NOTICES

Travis County Employee Health Benefit Fund Plan Document

The Use and Disclosure of Protected Health Information and Security of Electronic Protected Health Information

Under the federal privacy regulations enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your health plans are required to protect the confidentiality of your Protected Health Information. Protected Health Information (PHI) is individually identifiable health information related to your condition, services provided to you, or payments made for your care, which is created or received by a health plan, a health care clearinghouse, or a health care provider that electronically transmits such information. Travis County Employee Health Benefit Fund and Travis County, Texas will not use or disclose health information protected by HIPAA, except for treatment, payment, health plan operations (collectively known as "TPO"), as permitted or required by other state and federal law, or to business associates to help administer the Plan.

All disclosures of the PHI by a health insurance issuer or HMO to the Plan Sponsor will comply with the restrictions and requirements set forth in the Plan and in the "504" provisions.

The Plan may not disclose and may not permit a health insurance issuer or HMO to disclose members' PHI to the Plan Sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of

- Obtaining premium bids from health plans for providing health insurance coverage under the Plan, or
- Modifying, amending, or terminating the Plan.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the "504" provisions.

Further, Travis County, Texas will take reasonable steps to ensure that any use or disclosure is the minimum necessary to accomplish the task.

In addition, under the federal security regulations enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your health plans are required to safeguard the confidentiality and ensure the integrity and availability of your Electronic Protected Health Information. Electronic Protected Health Information (ePHI) is PHI that is maintained or transmitted in electronic form. Travis County Employee Health Benefit Fund and Travis County, Texas will reasonably and appropriately safeguard ePHI created, received, maintained, or transmitted to or by Travis County, Texas on behalf of the Plan.

The Plan and Travis County, Texas exchange information to coordinate your Plan coverage. Travis County, Texas agrees that it will:

- Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;
- Ensure that any agents, including subcontractors, to whom it provides PHI received from Travis County Employee Health Benefit Fund agree to the same restrictions and conditions that apply to Travis County, Texas with respect to such information;
- Not use or disclose PHI for employment-related actions and decisions;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of Travis County, Texas;
- Notify the Risk and Benefit Manager of any improper use or disclosure of PHI of which it becomes aware;
- Make PHI available to an individual based on HIPAA's access requirements;
- Make PHI available for amendment and incorporate any changes to PHI based on HIPAA's amendment requirements;
- Make available the information required to provide an accounting of disclosures of PHI;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with HIPAA;
- Ensure adequate separation between the Plan and other operations of Plan Sponsor as required by HIPAA; and
- If feasible, return or destroy all PHI received from Plan that other operations of Travis County, Texas still maintains in any form and retain no copies of such PHI when no longer needed for the specified disclosure purpose. If return or destruction is not feasible, Travis County, Texas will limit further uses and disclosures to those purposes that make the return or destruction infeasible.

In order to receive ePHI from the Plan for its other operations, Travis County, Texas agrees that it will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that any other operation of Travis County, Texas creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that access to, and use and disclosure of ePHI by the employees or classes of employees described in this Plan document is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom Travis County, Texas provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

- Report to the Risk and Benefit Manger any security incident of which Travis County, Texas becomes aware.

Only the following classes of employees under the control of Travis County, Texas may have access to PHI or ePHI:

- Designated HR Benefits Personnel. This class also includes those persons responsible for interacting with members, employees, providers, business associates, and others in resolving eligibility, benefits, claims, coordination of benefits, and other plan administration issues.
- Information Technology Administrators, Operations Support Personnel and Technical Support Personnel. These personnel include personnel responsible for creating and maintaining plan content, information, data sets and applications, and other related information Assets. These personnel may also be responsible for organization web sites, connectivity within the organization's networks, electronic mail, and connectivity with external networks.
- Clerical Personnel. These personnel include mail personnel, secretarial support, and others responsible for document handling and preparation.
- Supervision. Supervisors include only those persons who directly supervise other direct users of PHI.
- Financial Analysts for Health Plan.
- Benefit Administrator. This class also includes those responsible for preparing and submitting information to potential business associates and in managing performance of existing associates.

These employees may only have access to, and use and disclose, PHI for purposes of the plan administrative functions described in this Plan document.

If you believe your rights under HIPAA have been violated, you have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services. Travis County, Texas has provided a mechanism for resolving issues of noncompliance by employees described above who have access to PHI or ePHI. For more information about resolving issues of non-compliance, contract the Risk and Benefit Manager at the Human Resources Management Department, 2nd Floor, 1010 Lavaca Street, Austin, Texas, (512) 854-9499. Effective October 1, 2011, the address for the Risk and Benefit Manager will be the 4th Floor, 700 Lavaca Street, Austin, Texas, (512) 854-9499. All other terms, provisions, and conditions shown in your Health Benefits Plan Booklet will continue to apply. All other terms, provisions and conditions shown in this Summary Plan Description will continue to apply.

ATTACHMENT III - EARLY RETIREE REINSURANCE PROGRAM (ERRP) NOTICE

You are a Plan Member, or are being offered the opportunity to enroll as a Plan Member, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your Plan Sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in Plan Members' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the Plan Sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a Plan Member, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and the Plan Sponsor chooses to use the reimbursements for this purpose.

The Plan Sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are Members in this plan.

ADDENDUM - UNITEDHEALTH ALLIES

Introduction

This Addendum to the Summary Plan Description provides discounts for select non-Covered Health Services from Physicians and health care professionals.

When the words "you" and "your" are used the Addendum is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

> ***Important***:
> UnitedHealth Allies is not a health insurance plan. You are responsible for the full cost of any services purchased, minus the applicable discount. Always use your health insurance plan for Covered Health Services described in the Summary Plan Description (see Section 5, *Plan Highlights*) when a benefit is available.

What is UnitedHealth Allies?

UnitedHealth Allies is a health value program that offers savings on certain products and services that are not Covered Health Services under your health plan.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through UnitedHealth Allies are available to Covered Persons as defined in the Summary Plan Description in Section 14, *Glossary*.

Selecting a Discounted Product or Service

A list of available discounted products or services can be viewed online at **www.healthallies.com** or by calling the number on the back of your ID card.

After selecting a health care professional and product or service, reserve the preferred rate and print the rate confirmation letter. If you have reserved a product or service with a customer service representative, the rate confirmation letter will be faxed or mailed to you.

> ***Important***:
> You must present the rate confirmation at the time of receiving the product or service in order to receive the discount.

Visiting Your Selected Health Care Professional

After reserving a preferred rate, make an appointment directly with the health care professional. Your appointment must be within ninety (90) days of the date on your rate confirmation letter.

Present the rate confirmation and your ID card at the time you receive the service. You will be required to pay the preferred rate directly to the health care professional at the time the service is received.

Additional UnitedHealth Allies Information

Additional information on the UnitedHealth Allies program can be obtained online at **www.healthallies.com** or by calling the toll-free phone number on the back of your ID card.

SUMMARY OF MATERIAL MODIFICATIONS – EFFECTIVE JULY 1, 2011

Legal Entity Name Change: UnitedHealthcare (also known as United HealthCare Services, Inc.)

To the Summary Plan Description for Travis County Employee Health Benefit Fund

A Summary Plan Description (SPD) was published effective October 1, 2010. The following are modifications and clarifications that are effective July 1, 2011 unless otherwise stated. These modifications and clarifications are intended as a summary to supplement the SPD. It is important that you keep this summary with your SPD since this material plus the SPD comprise your complete SPD.

In the event of any discrepancy between this Summary of Material Modifications (SMM) and the SPD, the provisions of this SMM shall govern.

Section 16: IMPORTANT ADMINISTRATIVE INFORMATION	
Under Heading:	The Following Should be Noted:
Additional Plan Description	**Replace the Claims Administrator's name with the following.** United HealthCare Services, Inc. ***Additional Plan Description*** **Claims Administrator**: The claims administrator is the company which provides certain administrative services for the Plan Benefits described in this Summary Plan Description. That company is UnitedHealthcare (also known as United HealthCare Services, Inc.) and its affiliates. United HealthCare Services, Inc. Attn: Claims 185 Asylum Street Hartford, CT 06103-3408
	Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as UnitedHealthcare. For Benefits as described in this

	Summary Plan Description, the Plan Sponsor also has selected a provider network established by United HealthCare Services, Inc. The named fiduciary of the Plan is Travis County, the Plan Sponsor. The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

SUMMARY OF MATERIAL MODIFICATIONS – EFFECTIVE OCTOBER 1, 2011

Change to Prescription Solutions: Section 15 of the SPD is replaced in its entirety with the following new Section 15 – Prescription Drugs.

To the Summary Plan Description for Travis County Employee Health Benefit Fund

A Summary Plan Description (SPD) was published effective October 1, 2010. The following are modifications and clarifications that are effective October 1, 2011 unless otherwise stated. These modifications and clarifications are intended as a summary to supplement the SPD. It is important that you keep this summary with your SPD since this material plus the SPD comprise your complete SPD.

In the event of any discrepancy between this Summary of Material Modifications (SMM) and the SPD, the provisions of this SMM shall govern.

SECTION 15 - PRESCRIPTION DRUGS (10/1/2011 – 12/31/2011)

What this section includes:

- Benefits available for Prescription Drugs;
- How to utilize the retail and mail order service for obtaining Prescription Drugs;
- Any benefit limitations and exclusions that exist for Prescription Drugs; and
- Definitions of terms used throughout this section related to the Prescription Drug Plan.

Prescription Drug Coverage Highlights

The table below provides an overview of the Plan's Prescription Drug coverage. It includes Copay amounts that apply when you have a prescription filled at a Pharmacy. For detailed descriptions of your Benefits, refer to *Retail* and *Mail Order* in this section.

The Benefits described within this section apply to all Plans in the SPD.

You are responsible for paying any amounts due to the pharmacy at the time you receive your prescription drugs.

Note: Tier 1 was previously referred to as Generic, Tier 2 was previously referred to as Brand names when no Generic is available and Tier 3 was previously referred to as Brand-name when a Generic is available.

Covered Health Services[1]	Percentage of Prescription Drug Cost Payable by the Plan:	Percentage of Predominant Reimbursement Rate Payable by the Plan:
	Network	Non-Network
Retail - up to a 31-day supply[2]	100% after you pay a:	
■ tier-1, previously referred to as Generic	$10 Copay	
■ tier-2, previously referred to as Brand names when no Generic is available	$30 Copay	
■ tier-3, previously referred to as Brand Name when a Generic is available	$50 Copay	
Mail order - up to a 90-day supply[2,3]	100% after you pay a:	
■ tier-1	$20 Copay	
■ tier-2	$60 Copay	
■ tier-3	$100 Copay	

[1]You must notify UnitedHealthcare to receive full Benefits for certain Prescription Drugs. Otherwise, you may pay more out-of-pocket. See *Notification Requirements* in this section for details.

[2]The Plan pays Benefits for Specialty Prescription Drugs as described in this table.

[3]These supply limits do not apply to Specialty Prescription Drugs. Specialty Prescription Drugs from a mail order Network Pharmacy are subject to a 30-day supply limit.

Note: The Coordination of Benefits provision described in Section 10, *Coordination of Benefits (COB)* does not apply to covered Prescription Drugs as described in this section. Benefits for Prescription Drugs will not be coordinated with those of any other health coverage plan.

Identification Card (ID Card) – Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by UnitedHealthcare.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

Benefit Levels

Benefits are available for outpatient Prescription Drugs that are considered Covered Health Services.

The Plan pays Benefits at different levels for tier-1, tier-2 and tier-3 Prescription Drugs. All Prescription Drugs covered by the Plan are categorized into these three tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug, depending on its tier assignment. Since the PDL may change periodically, you can visit **www.myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card for the most current information.

Each tier is assigned a Copay, which is the amount you pay when you visit the pharmacy or order your medications through mail order. Your Copay will also depend on whether or not you visit the pharmacy or use the mail order service - see the table shown at the beginning of this section for further details. Here's how the tier system works:

- Tier-1 is your lowest Copay option. For the lowest out-of-pocket expense, you should consider tier-1 drugs if you and your Physician decide they are appropriate for your treatment.
- Tier-2 is your middle Copay option. Consider a tier-2 drug if no tier-1 drug is available to treat your condition.
- Tier-3 is your highest Copay option. The drugs in tier-3 are usually more costly. Usually there are alternatives available in tier-1 or tier-2.

For Prescription Drugs at a retail Network Pharmacy or from a mail order Network Pharmacy, you are responsible for paying the lowest of:

- the applicable Copay;
- the Network Pharmacy's Usual and Customary Charge for the Prescription Drug; or
- the Prescription Drug Cost that UnitedHealthcare agreed to pay the Network Pharmacy.

Retail

The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto **www.myuhc.com**.

To obtain your prescription from a retail pharmacy, simply present your ID card and pay the Copay. The Plan pays Benefits for certain covered Prescription Drugs:

- as written by a Physician;
- up to a consecutive 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on quantity limits;

- when a Prescription Drug is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copay that applies will reflect the number of days dispensed; and
- a one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Copay for each cycle supplied.

Note: Pharmacy Benefits apply only if your prescription is for a Covered Health Service and if prescribed by a Physician for dental services. If the Pharmacy Benefits apply to Experimental or Investigational, or Unproven Services, you are responsible for paying 100% of the cost.

Mail Order

The mail order service may allow you to purchase up to a 90-day supply of a covered maintenance drug through the Prescription Solutions Mail Order Pharmacy. Maintenance drugs help in the treatment of chronic illnesses, such as heart conditions, allergies, high blood pressure, and arthritis.

To use the mail order service, all you need to do is complete a patient profile and enclose your prescription order or refill. If you need an order form, patient profile, or if you have any questions, you can reach UnitedHealthcare at the toll-free number on your ID card.

To use the mail order service, choose the method that works best for you:

1. Call (**800) 562-6223**, 24 hours a day, 7 days a week. Keep your medication name and dosage handy. You'll also need your Physician's name and phone number. Prescription Solutions will call your Physician to get a new prescription.
2. Mail your original prescription, payment and completed order form to the address listed on the form. Write your date of birth on each prescription.
3. Your Physician can call in your prescription to (**800) 791-7658** or fax it to (**800) 491-7997**. Faxed prescriptions will only be accepted from a Physician's office.

Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received.

The Plan pays mail order Benefits for certain covered Prescription Drugs:

- as written by a Physician; and
- up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on quantity limits.

These supply limits do not apply to Specialty Prescription Drugs. Specialty Prescription Drugs from a mail order Network Pharmacy are subject to a 30-day supply limit as stated in the footnote to the Schedule limits under Covered Health Services.

You may be required to fill an initial Prescription Drug order and obtain one refill through a retail pharmacy prior to using a mail order Network Pharmacy.

Note: To maximize your benefit, ask your Physician to write your prescription order or refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copay for any prescription order or refill if you use the mail order service, regardless of the number of days' supply that is written on the order or refill. Be sure your Physician writes your mail order or refill for a 90-day supply, not a 30-day supply with three refills.

Designated Pharmacy

If you require certain Prescription Drugs, UnitedHealthcare may direct you to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drugs.

Specialty Prescription Drugs

You may fill a prescription for Specialty Prescription Drugs up to two times at any Network Pharmacy. However, after that you will be directed to a Designated Pharmacy and if you choose not to obtain your Specialty Prescription Drugs from a Designated Pharmacy, no Benefits will be paid and you will be responsible for paying all charges.

Please see the Prescription Drug Glossary in this section for definitions of Specialty Prescription Drug and Designated Pharmacy. Refer to the footnote in the table at the beginning of this section for details on Specialty Prescription Drug supply limits.

Want to lower your out-of-pocket Prescription Drug costs?
Consider Generic Prescription Drug Products, if you and your Physician decide they are appropriate.

Assigning Prescription Drugs to the PDL

UnitedHealthcare's Prescription Drug List (PDL) Management Committee makes the final approval of Prescription Drug placement in tiers. In its evaluation of each Prescription Drug, the PDL Management Committee takes into account a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include:

- evaluations of the therapeutic value;
- relative safety and efficacy; and
- whether supply limits or notification requirements should apply.

Economic factors may include:

- the acquisition cost of the Prescription Drug; and
- available rebates and assessments on the cost effectiveness of the Prescription Drug.

Some Prescription Drugs are more cost effective for specific indications as compared to others, therefore, a Prescription Drug may be listed on multiple tiers according to the indication for which the Prescription Drug was prescribed.

When considering a Prescription Drug for tier placement, the PDL Management Committee reviews clinical and economic factors about Covered Persons as a general population.

Whether a particular Prescription Drug is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

The PDL Management Committee may periodically change the placement of a Prescription Drug among the tiers. Placement of drugs on a higher tier will only occur twice a year; January 1 and July 1. You will be notified sixty days in advance if you are taking one of the impacted drugs. Placement of drugs on a lower tier may occur throughout the year without prior notice to you. These changes will not occur more than six times per calendar year and may occur without prior notice to you.

Prescription Drug, Prescription Drug List (PDL), and Prescription Drug List (PDL) Management Committee are defined at the end of this section.

Notification Requirements

Before certain Prescription Drugs are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to notify UnitedHealthcare. UnitedHealthcare will determine if the Prescription Drug, in accordance with UnitedHealthcare approved guidelines, is both:

- a Covered Health Service as defined by the Plan; and
- not Experimental or Investigational or Unproven, as defined in Section 14, *Glossary*.

Network Pharmacy Notification

When Prescription Drugs are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying UnitedHealthcare.

Non-Network Pharmacy Notification

When Prescription Drugs are dispensed at a Non-Network Pharmacy, you or your Physician are responsible for notifying UnitedHealthcare.

If UnitedHealthcare is not notified before the Prescription Drug is dispensed, you may pay more for that Prescription Drug order or refill. You will be required to pay for the Prescription Drug at the time of purchase. The contracted pharmacy reimbursement rates (the Prescription Drug Cost) will not be available to you at a Non-Network Pharmacy. If UnitedHealthcare is not notified before you purchase the Prescription Drug, you can request reimbursement after you receive the Prescription Drug - see Section 9, *Claims Procedures*, for information on how to file a claim.

When you submit a claim on this basis, you may pay more because you did not notify UnitedHealthcare before the Prescription Drug was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost (for Prescription Drugs from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drugs from a Non-Network Pharmacy), less the required Copayment and/or Coinsurance and any Deductible that applies.

To determine if a Prescription Drug requires notification, either visit **www.myuhc.com** or call the toll-free number on your ID card. The Prescription Drugs requiring notification are subject to UnitedHealthcare's periodic review and modification.

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

Prescription Drug Benefit Claims

For Prescription Drug claims procedures, please refer to Section 9, *Claims Procedures*.

Limitation on Selection of Pharmacies

If UnitedHealthcare determines that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, you may be required to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date UnitedHealthcare notifies you, UnitedHealthcare will select a single Network Pharmacy for you.

Quantity limits

Some Prescription Drugs are subject to quantity limits that may restrict the amount dispensed per prescription order or refill. To determine if a Prescription Drug has been assigned a maximum quantity level for dispensing, either visit **www.myuhc.com** or call the toll-free number on your ID card. Whether or not a Prescription Drug has a quantity limit is subject to UnitedHealthcare's periodic review and modification.

Note: Some products are subject to additional supply limits based on criteria that Travis County and UnitedHealthcare have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per prescription order or refill and/or the amount dispensed per month's supply.

If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug becomes available as a Generic drug, the tier placement of the Brand-name Drug may change. As a result, your Copay may change.

Special Programs

Travis County and UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced benefit based on your actions such as adherence/compliance to medication regimens. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on the back of your ID card.

Rebates and Other Discounts

UnitedHealthcare and Travis County may, at times, receive rebates from pharmaceutical companies for certain drugs on the PDL. UnitedHealthcare does not pass these rebates and

other discounts on to you nor does UnitedHealthcare take them into account when determining your Copays. All rebates, less an administrative fee paid to UnitedHealthcare, are retained in the Travis County Health Benefit Fund.

UnitedHealthcare and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this Prescription Drug section. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Prescription Drug section. UnitedHealthcare is not required to pass on to you, and does not pass on to you, such amounts.

Coupons, Incentives and Other Communications

UnitedHealthcare may send mailings to you or your Physician that communicate a variety of messages, including information about Prescription Drugs. These mailings may contain coupons or offers from pharmaceutical manufacturers that allow you to purchase the described Prescription Drug at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription order or refill is appropriate for your medical condition.

Exclusions - What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed under Section 8, *Exclusions* also apply to this section, except that any preexisting condition exclusion in Section 8, *Exclusions* is not applicable to this section. In addition, the following exclusions apply.

Medications that are:

1. dispensed in amounts that exceeds the quantity limit;

2. dispensed outside of the United States, except in an Emergency;

3. prescribed, dispensed or intended for use during an Inpatient Stay;

4. used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless UnitedHealthcare and Travis County have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in Section 14, *Glossary*;

5. any Prescription Drug for which payment or benefits are provided from the local, state or federal government whether or not payment or benefits are received, except as otherwise provided by law;

6. for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received;

7. prescribed for appetite suppression, and other weight loss products;

8. Pharmaceutical Products for which Benefits are provided in the medical (not in Section 15, *Prescription Drugs*) portion of the Plan;

9. Durable Medical Equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered);

10. vitamins, except for the following which require a prescription:

    - prenatal vitamins;
    - vitamins with fluoride; and
    - single entity vitamins.

11. unit dose packaging of Prescription Drugs;

12. used for cosmetic purposes;

13. Prescription Drugs, including new Prescription Drugs or new dosage forms, that Travis County determines do not meet the definition of a Covered Health Service;

14. Prescription Drug as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed;

15. prescribed to treat infertility;

16. compounded drugs that do not contain at least one ingredient that requires a prescription order or refill and has been approved by the U.S. Food and Drug Administration; Compounded drugs that are available as a similar commercially available Prescription Drug; (compounded drugs that contain at least one ingredient that requires a prescription order or refill are assigned to Tier-3);

17. available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless Travis County has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a prescription order or refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that Travis County has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and Travis County may decide at any time to reinstate Benefits for a Prescription Drug that was previously excluded under this provision;

18. new drugs and/or new dosages, until they are reviewed and assigned to a tier by the PDL Management Committee;

19. growth hormone for children with familial short stature based on heredity and not caused by a diagnosed medical condition);

20. oral non-sedating antihistamines or a combination of antihistamines and decongestants;

21. Prescription Drugs that contain (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug;

22. Prescription Drugs that contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug; and

23. typically administered by a qualified provider or licensed health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception;

Glossary - Prescription Drugs

Brand-name (Tier 2) - a Prescription Drug that is either:

- manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- identified by UnitedHealthcare as a Brand-name Drug based on available data resources including, but not limited to, First DataBank or Medi-Span that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by UnitedHealthcare.

Designated Pharmacy – a pharmacy that has entered into an agreement with UnitedHealthcare or with an organization contracting on its behalf, to provide specific Prescription Drugs including, but not limited to, Specialty Prescription Drugs. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic (Tier 1) - a Prescription Drug that is either:

- chemically equivalent to a Brand-name drug; or
- identified by UnitedHealthcare as a Generic Drug based on available data resources, including, but not limited to, First DataBank or Medi-Span that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by UnitedHealthcare.

Network Pharmacy - a retail or mail order pharmacy that has:

- entered into an agreement with UnitedHealthcare to dispense Prescription Drugs to Covered Persons;
- agreed to accept specified reimbursement rates for Prescription Drugs; and
- been designated by UnitedHealthcare as a Network Pharmacy.

Brand-name Drug When a Generic is Not available (Tier 3) - a Brand-name Drug that is not identified by UnitedHealthcare as being on the PDL.

PDL - see Prescription Drug List (PDL).

PDL Management Committee - see Prescription Drug List (PDL) Management Committee.

Predominant Reimbursement Rate – the amount the Plan will pay to reimburse you for a Prescription Drug Product that is dispensed at a Non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug dispensed at a Non-Network Pharmacy includes a dispensing fee and any applicable sales tax. UnitedHealthcare calculates the Predominant Reimbursement Rate using its Prescription Drug Cost that applies for that particular Prescription Drug at most Network Pharmacies.

Prescription Drug - a medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, only be dispensed using a prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of this Plan, Prescription Drugs include:

- inhalers (with spacers);
- insulin;
- the following diabetic supplies:
  - standard insulin syringes with needles;
  - blood testing strips - glucose;
  - urine testing strips - glucose;
  - ketone testing strips and tablets;
  - lancets and lancet devices;
  - insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets; and
  - glucose monitors.

Prescription Drug Cost – the rate UnitedHealthcare has agreed to pay its Network Pharmacies, including a dispensing fee and any applicable sales tax, for a Prescription Drug dispensed at a Network Pharmacy.

Prescription Drug List (PDL) - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration*. This list is subject to periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug has been assigned by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto **www.myuhc.com**.

Prescription Drug List (PDL) Management Committee - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

Specialty Prescription Drug - Prescription Drug that is generally high cost, self-injectable, oral or inhaled biotechnology drug used to treat patients with certain illnesses. For more information, visit **myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card.

Therapeutically Equivalent – when Prescription Drugs can be expected to produce essentially the same therapeutic outcome and toxicity.

Usual and Customary Charge – the usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

SUMMARY OF MATERIAL MODIFICATIONS - EFFECTIVE JANUARY 1, 2012

Addition of Formulary to Prescription Solutions: Section 15 of the SPD is replaced in its entirety with the following new Section 15 – Prescription Drugs.

To the Summary Plan Description for Travis County Employee Health Benefit Fund

A Summary Plan Description (SPD) was published effective October 1, 2010. The following are modifications and clarifications that are effective January 1, 2012 unless otherwise stated. These modifications and clarifications are intended as a summary to supplement the SPD. It is important that you keep this summary with your SPD since this material plus the SPD comprise your complete SPD.

In the event of any discrepancy between this Summary of Material Modifications (SMM) and the SPD, the provisions of this SMM shall govern.

SECTION 15 - PRESCRIPTION DRUGS (1/1/2012 – TBD)

What this section includes:

- Benefits available for Prescription Drugs;
- How to utilize the retail and mail order service for obtaining Prescription Drugs;
- Any benefit limitations and exclusions that exist for Prescription Drugs; and
- Definitions of terms used throughout this section related to the Prescription Drug Plan.

Prescription Drug Coverage Highlights

The table below provides an overview of the Plan's Prescription Drug coverage. It includes Copay amounts that apply when you have a prescription filled at a Pharmacy. For detailed descriptions of your Benefits, refer to *Retail* and *Mail Order* in this section.

The Benefits described within this section apply to all Plans in the SPD.

You are responsible for paying any amounts due to the pharmacy at the time you receive your prescription drugs.

Covered Health Services[1]	Percentage of Prescription Drug Cost Payable by the Plan:	Percentage of Predominant Reimbursement Rate Payable by the Plan:
	Network	Non-Network
Retail - up to a 31-day supply[2]	100% after you pay a:	
■ tier-1	$10 Copay	
■ tier-2	$30 Copay, plus any applicable Ancillary Charge	
■ tier-3	$50 Copay, plus any applicable Ancillary Charge	
Mail order - up to a 90-day supply[2,3]	100% after you pay a:	
■ tier-1	$20 Copay	
■ tier-2	$60 Copay, plus any applicable Ancillary Charge	
■ tier-3	$100 Copay, plus any applicable Ancillary Charge	

[1]You must notify UnitedHealthcare to receive full Benefits for certain Prescription Drugs. Otherwise, you may pay more out-of-pocket. See *Notification Requirements* in this section for details.

[2]The Plan pays Benefits for Specialty Prescription Drugs as described in this table.

[3]These supply limits do not apply to Specialty Prescription Drugs. Specialty Prescription Drugs from a mail order Network Pharmacy are subject to a 30-day supply limit.

Note: The Coordination of Benefits provision described in Section 10, *Coordination of Benefits (COB)* does not apply to covered Prescription Drugs as described in this section. Benefits for Prescription Drugs will not be coordinated with those of any other health coverage plan.

Identification Card (ID Card) – Network Pharmacy

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

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

Benefit Levels

Benefits are available for outpatient Prescription Drugs that are considered Covered Health Services.

The Plan pays Benefits at different levels for tier-1, tier-2 and tier-3 Prescription Drugs. All Prescription Drugs covered by the Plan are categorized into these three tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug, depending on its tier assignment. Since the PDL may change periodically, you can visit **www.myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card for the most current information.

Each tier is assigned a Copay, which is the amount you pay when you visit the pharmacy or order your medications through mail order. Your Copay will also depend on whether or not you visit the pharmacy or use the mail order service - see the table shown at the beginning of this section for further details. Here's how the tier system works:

- Tier-1 is your lowest Copay option. For the lowest out-of-pocket expense, you should consider tier-1 drugs if you and your Physician decide they are appropriate for your treatment.
- Tier-2 is your middle Copay option. Consider a tier-2 drug if no tier-1 drug is available to treat your condition.
- Tier-3 is your highest Copay option. The drugs in tier-3 are usually more costly. Sometimes there are alternatives available in tier-1 or tier-2.

For Prescription Drugs at a retail Network Pharmacy or mail order Network Pharmacy, you are responsible for paying the lowest of:

- the applicable Copay in addition to any Ancillary Charge, Therapeutic Class Charge, or Therapeutically Equivalent Charge;
- the Network Pharmacy's Usual and Customary Charge for the Prescription Drug; or
- the Prescription Drug Cost that UnitedHealthcare agreed to pay the Network Pharmacy.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug and the lower tiered drug in addition to your Copayment that applies to the applicable tier drug.

Retail

The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto **www.myuhc.com**.

To obtain your prescription from a retail pharmacy, simply present your ID card and pay the Copay and applicable Ancillary Charge. The Plan pays Benefits for certain covered Prescription Drugs:

- as written by a Physician;
- up to a consecutive 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on quantity limits;
- when a Prescription Drug is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copay that applies will reflect the number of days dispensed; and
- a one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Copay for each cycle supplied.

Note: Pharmacy Benefits apply only if your prescription is for a Covered Health Service and if prescribed by a Physician for dental services. If the Pharmacy Benefits apply to Experimental or Investigational, or Unproven Services, you are responsible for paying 100% of the cost.

Mail Order

The mail order service may allow you to purchase up to a 90-day supply of a covered maintenance drug through the Prescription Solutions Mail Order Pharmacy. Maintenance drugs help in the treatment of chronic illnesses, such as heart conditions, allergies, high blood pressure, and arthritis.

To use the mail order service, all you need to do is complete a patient profile and enclose your prescription order or refill. If you need an order form, patient profile, or if you have any questions, you can reach UnitedHealthcare at the toll-free number on your ID card.

To use the mail order service, choose the method that works best for you:

1. Call (**800) 562-6223**, 24 hours a day, 7 days a week. Keep your medication name and dosage handy. You'll also need your Physician's name and phone number. Prescription Solutions will call your Physician to get a new prescription.
2. Mail your original prescription, payment and completed order form to the address listed on the form. Write your date of birth on each prescription.
3. Your Physician can call in your prescription to (**800) 791-7658** or fax it to (**800) 491-7997**. Faxed prescriptions will only be accepted from a Physician's office.

Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received.

The Plan pays mail order Benefits for certain covered Prescription Drugs:

- as written by a Physician; and

- up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on quantity limits.

These supply limits do not apply to Specialty Prescription Drugs. Specialty Prescription Drugs from a mail order Network Pharmacy are subject to a 30-day supply limit as stated in the footnote to the Schedule limits under Covered Health Services.

You may be required to fill an initial Prescription Drug order and obtain one refill through a retail pharmacy prior to using a mail order Network Pharmacy.

Note: To maximize your benefit, ask your Physician to write your prescription order or refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copay for any prescription order or refill if you use the mail order service, regardless of the number of days' supply that is written on the order or refill. Be sure your Physician writes your mail order or refill for a 90-day supply, not a 30-day supply with three refills.

Designated Pharmacy

If you require certain Prescription Drugs, UnitedHealthcare may direct you to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drugs.

Specialty Prescription Drugs

You may fill a prescription for Specialty Prescription Drugs up to two times at any Network Pharmacy. However, after that you will be directed to a Designated Pharmacy and if you choose not to obtain your Specialty Prescription Drugs from a Designated Pharmacy, no Benefits will be paid and you will be responsible for paying all charges.

Please see the Prescription Drug Glossary in this section for definitions of Specialty Prescription Drug and Designated Pharmacy. Refer to the footnote in the table at the beginning of this section for details on Specialty Prescription Drug supply limits.

Want to lower your out-of-pocket Prescription Drug costs?
Consider Generic Prescription Drug Products, if you and your Physician decide they are appropriate.

Assigning Prescription Drugs to the PDL

UnitedHealthcare's Prescription Drug List (PDL) Management Committee makes the final approval of Prescription Drug placement in tiers. In its evaluation of each Prescription Drug, the PDL Management Committee takes into account a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include:

- evaluations of the therapeutic value;
- relative safety and efficacy; and
- whether quantity limits or notification requirements should apply.

Economic factors may include:

- the acquisition cost of the Prescription Drug; and
- available rebates and assessments on the cost effectiveness of the Prescription Drug.

Some Prescription Drugs are more cost effective for specific indications as compared to others, therefore, a Prescription Drug may be listed on multiple tiers according to the indication for which the Prescription Drug was prescribed.

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

The PDL Management Committee may periodically change the placement of a Prescription Drug among the tiers. Placement of drugs on a higher tier will only occur twice a year; January 1 and July 1. You will be notified sixty days in advance if you are taking one of the impacted drugs. Placement of drugs on a lower tier may occur throughout the year without prior notice to you. These changes will not occur more than six times per calendar year and may occur without prior notice to you.

Prescription Drug, Prescription Drug List (PDL), and Prescription Drug List (PDL) Management Committee are defined at the end of this section.

Notification Requirements

Before certain Prescription Drugs are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to notify UnitedHealthcare. UnitedHealthcare will determine if the Prescription Drug, in accordance with UnitedHealthcare approved guidelines, is both:

- a Covered Health Service as defined by the Plan; and
- not Experimental or Investigational or Unproven, as defined in Section 14, *Glossary*.

Network Pharmacy Notification

When Prescription Drugs are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying UnitedHealthcare.

Non-Network Pharmacy Notification

When Prescription Drugs are dispensed at a Non-Network Pharmacy, you or your Physician are responsible for notifying UnitedHealthcare.

If UnitedHealthcare is not notified before the Prescription Drug is dispensed, you may pay more for that Prescription Drug order or refill. You will be required to pay for the Prescription Drug at the time of purchase. The contracted pharmacy reimbursement rates (the Prescription Drug Cost) will not be available to you at a Non-Network Pharmacy. If

UnitedHealthcare is not notified before you purchase the Prescription Drug, you can request reimbursement after you receive the Prescription Drug - see Section 9, *Claims Procedures*, for information on how to file a claim.

When you submit a claim on this basis, you may pay more because you did not notify UnitedHealthcare before the Prescription Drug was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost (for Prescription Drugs from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drugs from a Non-Network Pharmacy), less the required Copayment, Ancillary Charge and any Deductible that applies.

To determine if a Prescription Drug requires notification, either visit **www.myuhc.com** or call the toll-free number on your ID card. The Prescription Drugs requiring notification are subject to UnitedHealthcare's periodic review and modification.

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

Prescription Drug Benefit Claims

For Prescription Drug claims procedures, please refer to Section 9, *Claims Procedures*.

Limitation on Selection of Pharmacies

If UnitedHealthcare determines that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, you may be required to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date UnitedHealthcare notifies you, UnitedHealthcare will select a single Network Pharmacy for you.

Quantity limits

Some Prescription Drugs are subject to quantity limits that may restrict the amount dispensed per prescription order or refill. To determine if a Prescription Drug has been assigned a maximum quantity level for dispensing, either visit **www.myuhc.com** or call the toll-free number on your ID card. Whether or not a Prescription Drug has a quantity limit is subject to UnitedHealthcare's periodic review and modification.

Note: Some products are subject to additional quantity limits based on criteria that Travis County and UnitedHealthcare have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per prescription order or refill and/or the amount dispensed per month's supply.

If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug becomes available as a Generic drug, the tier placement of the Brand-name Drug may change. As a result, your Copay may change and an Ancillary

Charge may apply. You will pay the Copay applicable for the tier to which the Prescription Drug is assigned.

Special Programs

Travis County and UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced benefit based on your actions such as adherence/compliance to medication regimens. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on the back of your ID card.

Rebates and Other Discounts

UnitedHealthcare and Travis County may, at times, receive rebates from pharmaceutical companies for certain drugs on the PDL. UnitedHealthcare does not pass these rebates and other discounts on to you nor does UnitedHealthcare take them into account when determining your Copays. All rebates, less an administrative fee paid to UnitedHealthcare, are retained in the Travis County Health Benefit Fund.

UnitedHealthcare and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this Prescription Drug section. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Prescription Drug section. UnitedHealthcare is not required to pass on to you, and does not pass on to you, such amounts.

Coupons, Incentives and Other Communications

UnitedHealthcare may send mailings to you or your Physician that communicate a variety of messages, including information about Prescription Drugs. These mailings may contain coupons or offers from pharmaceutical manufacturers that allow you to purchase the described Prescription Drug at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription order or refill is appropriate for your medical condition.

Exclusions - What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed under Section 8, *Exclusions* also apply to this section, except that any preexisting condition exclusion in Section 8, *Exclusions* is not applicable to this section. In addition, the following exclusions apply.

Medications that are:

1. dispensed in amounts that exceeds the quantity limit;

2. dispensed outside of the United States, except in an Emergency;

3. prescribed, dispensed or intended for use during an Inpatient Stay;

4. used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless UnitedHealthcare and Travis County have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in Section 14, *Glossary*;

5. any Prescription Drug for which payment or benefits are provided from the local, state or federal government whether or not payment or benefits are received, except as otherwise provided by law;

6. for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received;

7. prescribed for appetite suppression, and other weight loss products;

8. Pharmaceutical Products for which Benefits are provided in the medical (not in Section 15, *Prescription Drugs*) portion of the Plan;

9. Durable Medical Equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered);

10. vitamins, except for the following which require a prescription:

    - prenatal vitamins;
    - vitamins with fluoride; and
    - single entity vitamins.

11. unit dose packaging of Prescription Drugs;

12. used for cosmetic purposes;

13. Prescription Drugs, including new Prescription Drugs or new dosage forms, that Travis County determines do not meet the definition of a Covered Health Service;

14. Prescription Drug as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed;

15. prescribed to treat infertility;

16. compounded drugs that do not contain at least one ingredient that requires a prescription order or refill and has been approved by the U.S. Food and Drug Administration; compounded drugs that are available as a similar commercially available Prescription Drug; (Compounded drugs that contain at least one ingredient that requires a prescription order or refill are assigned to Tier-3);

17. available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless Travis County has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained

with a prescription order or refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that Travis County has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and Travis County may decide at any time to reinstate Benefits for a Prescription Drug that was previously excluded under this provision;

18. new drugs and/or new dosages, until they are reviewed and assigned to a tier by the PDL Management Committee;

19. growth hormone for children with familial short stature based on heredity and not caused by a diagnosed medical condition);

20. oral non-sedating antihistamines or a combination of antihistamines and decongestants;

21. Prescription Drugs that contain (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug;

22. Prescription Drugs that contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug; and

23. typically administered by a qualified provider or licensed health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception;

Glossary - Prescription Drugs

Ancillary Charge – a charge, in addition to the Copayment, that you are required to pay when a covered Prescription Drug is dispensed at your or the provider's request, when a chemically equivalent Prescription Drug is available on a lower tier. For Prescription Drugs from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug on the higher tier, and the Prescription Drug Charge or MAC List price of the chemically equivalent Prescription Drug available on the lower tier.

Brand-name - a Prescription Drug that is either:

- manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- identified by UnitedHealthcare as a Brand-name Drug based on available data resources including, but not limited to, Medi-Span that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by UnitedHealthcare.

Copayment (or Copay) – the set dollar amount you are required to pay for certain Prescription Drugs.

Designated Pharmacy – a pharmacy that has entered into an agreement with UnitedHealthcare or with an organization contracting on its behalf, to provide specific Prescription Drugs including, but not limited to, Specialty Prescription Drugs. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug that is either:

- chemically equivalent to a Brand-name drug; or
- identified by UnitedHealthcare as a Generic Drug based on available data resources, including, but not limited to, Medi-Span that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by UnitedHealthcare.

Maximum Allowable Cost (MAC) List – a list of Generic Prescription Drugs that will be covered at a price level that the Claims Administrator establishes. This list is subject to periodic review and modification.

Network Pharmacy - a retail or mail order pharmacy that has:

- entered into an agreement with UnitedHealthcare to dispense Prescription Drugs to Covered Persons;
- agreed to accept specified reimbursement rates for Prescription Drugs; and
- been designated by UnitedHealthcare as a Network Pharmacy.

PDL - see Prescription Drug List (PDL).

PDL Management Committee - see Prescription Drug List (PDL) Management Committee.

Predominant Reimbursement Rate – the amount the Plan will pay to reimburse you for a Prescription Drug Product that is dispensed at a Non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug dispensed at a Non-Network Pharmacy includes a dispensing fee and any applicable sales tax. UnitedHealthcare calculates the Predominant Reimbursement Rate using its Prescription Drug Cost that applies for that particular Prescription Drug at most Network Pharmacies.

Prescription Drug - a medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, only be dispensed using a prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of this Plan, Prescription Drugs include:

- inhalers (with spacers);
- insulin;
- the following diabetic supplies:
  - standard insulin syringes with needles;
  - blood testing strips - glucose;
  - urine testing strips - glucose;
  - ketone testing strips and tablets;
  - lancets and lancet devices;
  - insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets; and
  - glucose monitors.

Prescription Drug Cost – the rate UnitedHealthcare has agreed to pay its Network Pharmacies, including a dispensing fee and any applicable sales tax, for a Prescription Drug dispensed at a Network Pharmacy.

Prescription Drug List (PDL) - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration*. This list is subject to periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug has been assigned by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto **www.myuhc.com**.

Prescription Drug List (PDL) Management Committee - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

Specialty Prescription Drug - Prescription Drug that is generally high cost, self-injectable, oral or inhaled biotechnology drug used to treat patients with certain illnesses. For more information, visit **myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card.

Therapeutic Class – a group or category of Prescription Drug with similar uses and/or actions.

Therapeutically Equivalent – when Prescription Drugs can be expected to produce essentially the same therapeutic outcome and toxicity.

Usual and Customary Charge – the usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.