Summary Plan Description

for

Choice / Choice Plus

Standard Plan Designs and Standard Options

Group Number: 713863

Effective Date: May 1, 2008

Table of Contents

Introduction 1

How to Use this Document 1
Information about Defined Terms 1
Your Contribution to the Benefit Costs 1
Customer Service and Claims Submittal 1

Section 1: What's Covered--Benefits 3

Accessing Benefits 3
Copayment 4
Eligible Expenses 4
Notification Requirements 4
Payment Information 7
Annual Deductible 7
Out-of-Pocket Maximum 7
Maximum Plan Benefit 8
Benefit Information 9
1. Acupuncture Services 9
2. Ambulance Services - Emergency only 9
3. Ambulance Services - Non-Emergency 10
4. Bariatric Procedures 10
Please remember that you must notify the Claims Administrator five business days before receiving services. If you don't notify the Claims Administrator, Benefits otherwise available will be reduced by $250. 11
5. Diagnostic Services 11
6. Dental Services - Accident only 12
7. Durable Medical Equipment 14
8. Emergency Health Services 16
9. Eye Examinations 17
10. Hearing Care 17
11. Home Health Care 18
11. Hospice Care 20
12. Hospital - Inpatient Stay 20
13. Infertility Services and Voluntary Sterilization 21
14. Injections received in a Physician's Office 22
15. Maternity Services 22
16. Mental Health and Substance Abuse Services - Outpatient 23
17. Mental Health and Substance Abuse Services - Inpatient and Intermediate 24
18. Nutritional Counseling 25
20. Outpatient Surgery 26
21. Physician's Office Services – Primary Care 27
23. Private Duty Nursing 28
24. Professional Fees for Surgical and Medical Services 29
25. Prosthetic Devices 29
26. Reconstructive Procedures 30
27. Rehabilitation Services - Outpatient Therapy 31
Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Annual maximum is

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

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

45 visits for any combination of Rehabilitation Services and Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy........32
28. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services........33
29. Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy........34
30. Transplantation Services........35
31. Therapeutic Services........38
32. Urgent Care Center Services........39

Section 2: What's Not Covered--Exclusions........40

How We Use Headings in this Section........40
Plan Exclusions........40
A. Alternative Treatments........40
B. Comfort or Convenience........40
C. Dental........41
D. Drugs........41
E. Experimental or Investigational Services or Unproven Services........41
F. Foot Care........41
G. Medical Supplies and Appliances........42
H. Mental Health/Substance Abuse........42
I. Nutrition........43
J. Physical Appearance........43
K. Providers........44

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

L. Reproduction........44
M. Services Provided under Another Plan........44
N. Transplants........45
O. Travel........45
P. Vision........45
Q. All Other Exclusions........45

Section 3: Description of Network and Non-Network Benefits........48

Network Benefits........48
Non-Network Benefits........50
Emergency Health Services........51

Section 4: When Coverage Begins........52

How to Enroll........52
If You Are Hospitalized When Your Coverage Begins........52
If You Are Eligible for Medicare........52
Who is Eligible for Coverage........53
Eligible Person........53
Dependent........53
When to Enroll and When Coverage Begins........54
Initial Enrollment Period........54
Open Enrollment Period........54
New Eligible Persons........54
Adding New Dependents........56
Special Enrollment Period........57

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

Section 5: How to File a Claim.................... 59

If You Receive Covered Health Services from a Network Provider 59

Filing a Claim for Benefits 59

Section 6: Questions and Appeals 63

What to Do First 63

How to Appeal a Claim Decision 63

Appeal Process 64

Appeals Determinations 64

Urgent Claim Appeals that Require Immediate Action 64

Voluntary External Review Program 65

Section 7: Coordination of Benefits............. 66

Benefits When You Have Coverage under More than One Plan66

When Coordination of Benefits Applies 66

Definitions 66

Order of Benefit Determination Rules 68

Effect on the Benefits of this Plan 70

Right to Receive and Release Needed Information 71

Payments Made 71

Right of Recovery 71

Section 8: When Coverage Ends 72

General Information about When Coverage Ends 72

Events Ending Your Coverage 73

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

The Entire Plan Ends 73

You Are No Longer Eligible 73

Your LTF Withdraws from the BAC HCPC 73

Other Events Ending Your Coverage 74

Fraud, Misrepresentation or False Information 74

Material Violation 74

Improper Use of ID Card 74

Failure to Pay 74

Threatening Behavior 74

Coverage for a Handicapped Child 75

Continuation of Coverage 75

Continuation Coverage under Federal Law (COBRA) 75

Qualifying Events for Continuation Coverage under COBRA .76

Notification Requirements and Election Period for Continuation Coverage under COBRA 76

COBRA Terminating Events 78

Uniformed Services Employment and Reemployment Rights Act 79

Section 9: General Legal Provisions............. 81

Plan Document 81

Relationship with Providers 81

Your Relationship with Providers 81

Incentives to Providers 82

Incentives to You 82

Rebates and Other Payments 82

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

Interpretation of Benefits.. 82
Administrative Services.. 83
Amendments to the Plan 83
Clerical Error.. 83
Information and Records 84
Examination of Covered Persons.. 84
Workers' Compensation not Affected....................................... 84
Medicare Eligibility... 84
Subrogation and Reimbursement.. 85
Refund of Overpayments... 87
Limitation of Action.. 88

Section 10: Glossary of Defined Terms........ 89

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

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

Introduction

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

How to Use this Document

We encourage you to read your SPD and the inserted Schedule-of-Benefits sheet along with any attached Riders, Addendums and/or Amendments carefully.

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

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

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

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

Information about Defined Terms

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

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

Your Contribution to the Benefit Costs

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

Customer Service and Claims Submittal

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

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

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

Claims Administrator/Notification: As shown on your ID card.

Mental Health/Substance Abuse Services Designee: As shown on your ID card.

Claims Submittal Address:

United HealthCare Insurance Company

Attention: Claims

P.O. Box 30555

Salt Lake City, UT 84130-0555

Requests for Review of Denied Claims and Notice of Complaints:

Name and Address For Submitting Requests:

United HealthCare Insurance Company

Attention: Appeals

P.O. Box 30432

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

Salt Lake City, UT 84130-0433

Internet:

We also encourage you to visit the Claims Administrator's website, www.myuhc.com, to take advantage of several self-service features including: viewing your claims' status, ordering ID cards and finding Network Physicians in your area.

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 and Eligible Expenses.
- Annual Deductible, Out-of-Pocket Maximum and Maximum Plan Benefit.
- Covered Health Services. We pay Benefits for the Covered Health Services described in this section unless they are listed as not covered in (Section 2: What's Not Covered--Exclusions).
- Covered Health Services that require you or your provider to notify the Claims Administrator before you receive them. In general, Network providers are responsible for notifying the Claims Administrator before they provide certain health services to you. You are responsible for notifying the Claims Administrator (a phone number is listed on your ID card) before you receive certain health services from a non-Network provider.

Accessing Benefits

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

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive. For details about when Network Benefits apply, see (Section 3: Description of Network and Non-Network Benefits).

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

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

If there is not a Network Physician in your area, you must get prior approval from the Claims Administrator in order to receive Network Benefits while using a Non-Network health care providers. In general, approval is only granted if the closest Network provider required for your medical condition is further than 30 miles from your home. If you are granted permission to use a Non-Network provider you are responsible for notifying the Claims Administrator for health services which require prior notification(see Notification Requirements) since you are using a Non-Network provider.

Copayment

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

Eligible Expenses

Eligible Expenses for Covered Health Services, incurred while the Plan is in effect, are determined by us or by our designee once you have met your Annual Deductible. In almost all cases our designee is the Claims Administrator. For a complete definition of Eligible Expenses that describes how payment is determined, see (Section 10: Glossary of Defined Terms).

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

When you receive Covered Health Services from Network providers, you are responsible for the Copayment and amounts in excess of any Plan maximum, but you are not responsible for any difference between the Eligible Expenses and the amount the Network provider bills. When you receive Covered Health Services from non-Network providers, except for fees that are negotiated by a non-Network provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors, you are responsible for paying, directly to the Non-Network provider, the Copayment, any difference between the amount the provider bills you and the amount we will pay toward Eligible Expenses, and any amounts in excess of any Plan maximum.

Notification Requirements

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

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

Services for which you must provide prior notification appear in this section under the *Must You Notify The Claims Administrator*? column in the table labeled *Benefit Information*. Below are the services that require notification:

- Accidental Dental Services.
- Non-Network services for special clinical circumstance
- Congenital Heart Disease Services.
- Durable Medical Equipment over $1,000.
- Home Health Care.
- Hospice Care.
- Hospital Confinements.

- Maternity Care that exceeds 48 hours for normal delivery and 96 hours for Caesarian birth.
- Mental Health and Substance Abuse Services.
- Reconstructive Procedures.
- Skilled Nursing/Inpatient Rehabilitation Facility Confinement.
- Transplant or Transplant-Related Services.
- Breast reduction and reconstruction (except for after cancer surgery), vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty. These services will not be covered when considered cosmetic in nature.
- Bariatric procedure (requires additional eligibility and medical condition requirements)
- Cancer Treatments
- Services for treatment of End Stage Renal Disease
- Non-Emergency Ambulance Transportation
- Rehabilitation over 20 visits per year
- Chiropractic over 20 visits per year

Network providers are required to do the notification. You MUST do the notification if you use a Non-Network provider. ***Failure to notify the Claims Administrator when using a Non-Network provider will result in a benefit reduction of $250 even if you are receiving Network benefits.***

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

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

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

Special Note Regarding Medicare

If you are enrolled for Medicare on a primary basis (Medicare pays before we pay Benefits under the Plan), the notification requirements described in this SPD do not apply to you. When Medicare is the primary payer, we will pay Benefits according to the provisions of the Plan as secondary payer (after Medicare pays) as described in (Section 7: Coordination of Benefits). You are not required to notify the Claims Administrator before receiving Covered Health Services when Medicare is the

primary payer.

Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services before you are eligible to receive Non-Network Benefits. For a complete definition of Annual Deductible, see (Section 10: Glossary of Defined Terms). The Annual Deductible is calculated based on the date of service during a 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. For a complete definition of Eligible Expenses, see (Section 10: Glossary of Defined terms).	*Network* Please refer to the insert Schedule-of-Benefits *Non-Network* Please refer to the insert Schedule-of-Benefits
Out-of-Pocket Maximum	The maximum you pay, out of your pocket excluding Deductibles and Copayments, in a Calendar year for Copayments. For a complete definition of Out-of-Pocket Maximum, see (Section 10: Glossary of Defined Terms).	*Network* Please refer to the insert Schedule-of-Benefits *Non-Network* Please refer to the insert Schedule-of-Benefits

Payment Term	Description	Amounts
Maximum Plan Benefit	The maximum amount we will pay for Network and Non-Network Benefits during the entire period or periods of time you are enrolled under the Plan. For a complete definition of Maximum Plan Benefit, see (Section 10: Glossary of Defined Terms).	***Network*** Please refer to the insert Schedule-of-Benefits ***Non-Network*** Please refer to the insert Schedule-of-Benefits

Benefit Information

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
1. Acupuncture Services Acupuncture services for pain therapy when both of the following are true:	*Network* No	Please refer to the insert Schedule-of-Benefits
• The service is performed by a provider in the provider's office. • The service is performed by a licensed acupuncturist and practicing within the scope of the license.	*Non-Network* No	Please refer to the insert Schedule-of-Benefits
Any combination of Network and Non-Network Benefits is limited to 20 visits per Calendar year.		
2. Ambulance Services - Emergency only Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.	*Network* No	*Ground or Air Transportation:* Please refer to the insert Schedule-of-Benefits

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
	Non-Network No	Same as Network
3. Ambulance Services - Non-Emergency Transportation by professional ambulance (not including air ambulance) to and from a medical facility. Transportation by regularly-scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment.	***Network*** No	*Ground or Air Transportation:* Please refer to the insert Schedule-of-Benefits
Notify the Claims Administrator Please remember that for Non-Network Benefits you should notify the Claims Administrator five business days before receiving services. If you don't notify the Claims Administrator, Benefits otherwise available will be subject to a reduction of $250.	***Non-Network*** Yes	Please refer to the insert Schedule-of-Benefits
4. Bariatric Procedures Surgical treatment of morbid obesity received on an inpatient basis in a Hospital. All of the following criteria must be met: • Covered Person must have a minimum BMI of 35 with documentation of treatment of cardiac disease, diabetes, lung	***Network*** No	Please refer to the insert Schedule-of-Benefits

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
disease or peripheral vascular disease; • $5,000 per surgery then covered same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices. • Covered Person must have met the BMI criterion for the last three years; and • Covered Person must be over the age of 21. • Covered Person must have been in the Plan over 1 year.	***Non-Network*** Yes	
Notify the Claims Administrator **Please remember that you must notify the Claims Administrator five business days before receiving services. If you don't notify the Claims Administrator, Benefits otherwise available will be reduced by $250.**		

5. Diagnostic Services

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount
Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including: • Laboratory test Imaging and radiology/X-ray.	***Network*** No	Please refer to the insert Schedule-of-Benefits

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
• Mammography testing. • Other diagnostic tests Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees related to diagnostic services are described under *Professional Fees for Surgical and Medical Services* below. When minor laboratory tests are performed in and billed by a Physician's office, Benefits are described under *Physician's Office Services* below.	***Non-Network*** No	
6. Dental Services - Accident only Dental services when all of the following are true: • Treatment is necessary because of accidental damage. • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D.". • The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident.	***Network*** No	Please refer to the insert Schedule-of-Benefits
Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured	***Non-Network***	Please refer to

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
tooth was: • A virgin or unrestored tooth, or • A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech. Dental services for final treatment to repair the damage must be both of the following: • Started within three months of the accident. • Completed within 12 months of the accident. Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities. **Notify the Claims Administrator** Please remember that you should notify the Claims Administrator as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. (You do not have to provide notification before the initial Emergency treatment.) When you provide notification, the Claims Administrator can verify that the service is a Covered Health	Yes	the insert Schedule-of-Benefits

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
Service.		

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.
- Not consumable or disposable.
- Not of use to a person in the absence of a disease or disability.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen concentrator units and the rental of equipment to administer oxygen.
- Delivery pumps for tube feedings (including tubing and

	Must You Notify the Claims Administrator?	Your Copayment Amount
Network	No	Please refer to the insert Schedule-of-Benefits
Non-Network	Yes, for items more than $1,000	Please refer to the insert Schedule-of-Benefits

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
connectors). • Braces that stabilize an Injured body part are considered Durable Medical Equipment and are a Covered Health Service, including necessary adjustments to shoes to accommodate braces. • Mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions. We provide Benefits for a single unit of Durable Medical Equipment (example: one insulin pump) and provide repair for that unit. Benefits are provided for the replacement of a type of Durable Medical Equipment once every three calendar years. **Notify the Claims Administrator** Please remember that for Non-Network Benefits you must notify the Claims Administrator before obtaining any single item of Durable Medical Equipment that costs more than $1,000 (either purchase price or cumulative rental of a single item). 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?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
If you don't notify the Claims Administrator, Benefits for Durable Medical Equipment otherwise will be reduced by $250.		
8. Emergency Health Services Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.	*Network* No	Please refer to the insert Schedule-of-Benefits
You will find more information about Benefits for Emergency Health Services in (Section 3: Description of Network and Non-Network Benefits). **Notify the Claims Administrator** Please remember that if you are admitted to a Non-Network Hospital as a result of an Emergency, you must notify the Claims Administrator within two business days or the same day of admission, or as soon as reasonably possible. If you don't notify the Claims Administrator, Benefits for the Non-Network Hospital Inpatient Stay will be subject to a reduction of $250. Benefits will not be reduced for the	*Non-Network* Yes, but only for an Inpatient Stay	*True Emergency:* Same as Network *Non-Emergency:* Please refer to the insert Schedule-of-Benefits

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
outpatient Emergency Health Services.		
9. Eye Examinations Eye examinations received from a health care provider in the provider's office. The Plan covers charges for tests and treatment due to illness or Injury only. Routine eye exams are not covered.	*Network* No	Please refer to the insert Schedule-of-Benefits
Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.	*Non-Network* No	Please refer to the insert Schedule-of-Benefits
10. Hearing Care Hearing examinations and associated covered services received from a health care provider in the provider's office.	*Network* No	Please refer to the insert Schedule-of-Benefits
Benefits are available for charges connected to the purchase or fitting of hearing aids and are limited to $1,000 per Covered Person per lifetime.	*Non-Network* No	Please refer to the insert Schedule-of-Benefits

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
11. Home Health Care Services received from a Home Health Agency that are both of the following: • Ordered by a Physician. • Provided by or supervised by a registered nurse in your home. Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled home health care is required. Skilled home health care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true: • It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient. • It is ordered by a Physician. • It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair. • It requires clinical training in order to be delivered safely and effectively. • It is not Custodial Care.	***Network*** No ***Non-Network*** Yes	Please refer to the insert Schedule-of-Benefits Please refer to the insert Schedule-of-Benefits

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses
The Claims Administrator will decide if skilled home health care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver. Any combination of Network and Non-Network Benefits is limited to 40 visits per calendar year. One visit equals four hours of skilled care services. **Notify the Claims Administrator** Please remember that for Non-Network Benefits you should notify the Claims Administrator five business days before receiving services. If you don't notify the Claims Administrator, Benefits otherwise available will be subject to a reduction of $250.		

11. Hospice Care

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

Network
No

Please refer to the insert Schedule-of-Benefits

Notify the Claims Administrator

Please remember that for Non-Network Benefits you should notify the Claims Administrator five business days before receiving services. If you don't notify the Claims Administrator, Benefits otherwise available will be subject to a reduction of $250.

Non-Network
Yes

Please refer to the insert Schedule-of-Benefits

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 (a room with two or more patient beds).

Network
No

Please refer to the insert Schedule-of-Benefits

Notify the Claims Administrator

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

Non-Network
Yes

Please refer to the insert Schedule-of-

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

If you don't notify the Claims Administrator, Benefits otherwise available will be subject to a reduction of $250.

Benefits

13. Infertility Services and Voluntary Sterilization

Covered Health Services and associated expenses for the diagnosis and treatment of an underlying medical condition which causes infertility when provided by or under the direction of a Physician.

Voluntary Sterilization service includes:

- Vasectomy
- Tubal Ligation

Reversal of sterilization is not a covered service.

Network	No	Please refer to the insert Schedule-of-Benefits
Non-Network	No	Please refer to the insert Schedule-of-Benefits

14. Injections received in a Physician's Office

Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy. This is not part of the Physician Office Services benefits.

Network	No	Please refer to the insert Schedule-of-Benefits
Non-Network	No	Please refer to the insert Schedule-of-Benefits

15. 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 is a special prenatal program to help during Pregnancy. It is completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify the Claims Administrator during the first trimester, but no later than one month prior to the anticipated childbirth.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery.

Network	No	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Diagnostic and Therapeutic Services
		Please refer to the insert Schedule-of-Benefits

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

16. 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. • Psychological testing.	***Network*** No	***Mental Health:*** Please refer to the insert Schedule-of-Benefits ***Substance Abuse:*** Please refer to the insert Schedule-of-Benefits
Any combination of Network and Non-Network Benefits for Mental Health and Substance Abuse Services is limited to 45 visits per calendar year.	***Non-Network*** You must call the Mental	***Mental Health:*** Please refer to the insert

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. **Notify the Claims Administrator** For Non-Network Benefits, contact the Claims Administrator to speak with the Mental Health/Substance Abuse Designee prior to receiving services. For Non-Network Benefits, without authorization, you will be responsible for paying all charges and no Benefits will be paid.	Health/ Substance Abuse Designee to receive the Benefits	Schedule-of-Benefits ***Substance Abuse:*** Please refer to the insert Schedule-of-Benefits

17. Mental Health and Substance Abuse Services - Inpatient and Intermediate

Mental Health Services and Substance Abuse Services received on an inpatient or intermediate care basis in a Hospital or an Alternate Facility. Benefits include detoxification from abusive chemicals or substances that is limited to physical detoxification when necessary to protect your physical health and well-being.	***Network*** No	Please refer to the insert Schedule-of-Benefits
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	***Non-Network*** You must call the Mental Health/ Substance	Please refer to the insert Schedule-of-Benefits

inpatient day. Network Benefits for Mental Health Services and Substance Abuse Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. For Network Benefits, referrals to a Mental Health/Substance Abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for inpatient/intermediate Mental Health Services and Substance Abuse Services. Any combination of Network and Non-Network Benefits for Mental Health Services is limited to 30 days per calendar year. Any combination of Network and Non-Network Benefits for Substance Abuse Services is limited to 30 days per calendar year. **Notify the Claims Administrator** For Non-Network Benefits, contact the Claims Administrator to speak with the Mental Health/Substance Abuse Designee prior to receiving services. For Non-Network Benefits, without authorization, you will be responsible for paying all charges and no Benefits will be paid.	Abuse Designee to receive the Benefits.	. ***Substance Abuse:*** Please refer to the insert Schedule-of-Benefits .
18. Nutritional Counseling Covered Health Services provided by a registered dietician in an individual session for Covered Persons with medical conditions that require a special diet. Some examples of such medical conditions include:	***Network*** No	Please refer to the insert Schedule-of-Benefits

- Diabetes mellitus.
- Coronary artery disease.
- Congestive heart failure.
- Severe obstructive airway disease.
- Gout.
- Renal failure.
- Phenylketonuria.
- Hyperlipidemias.

Benefits are limited to three individual sessions during a Covered Person's lifetime for each medical condition.

Non-Network

No

Please refer to the insert Schedule-of-Benefits

20. Outpatient Surgery

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

- Surgery and related services
- Ambulatory Surgical Center Services
- Anesthetics

Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient surgery are described under *Professional Fees for Surgical and Medical Services* below.

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

Network

No

Please refer to the insert Schedule-of-Benefits

Non-Network

No

Please refer to the insert Schedule-of-Benefits

21. Physician's Office Services – Primary Care

Covered Health Services and Supplies, other than non-minor surgical procedures and related supplies, rendered by a Primary Care Physician and received in the Physician's office including:

- Primary Care Physician includes general practice Physician, family practice physician, pediatrician, internist, chiropractor, obstetrician/gynecologist (OB/GYN) only for annual exams, nurse practitioner in any of the above practices or a covering physician of similar medical practice.
- Treatment of a Sickness or Injury.
- Preventive Care.
- Voluntary family planning.
- Well-baby and well-child care.
- Routine well woman examinations, including pap smears, pelvic examinations and mammograms.
- Routine well man examinations, including prostate-specific antigen (PSA) tests.
- Routine physical examinations, including vision and hearing screenings. (Vision screenings do not include refractive examinations to detect or measure vision impairment. See *Eye Examinations* earlier in this section.)
- Immunizations.

Network

No

Please refer to the insert Schedule-of-Benefits

Non-Network

No

Please refer to the insert Schedule-of-Benefits

22. Physician's Office Services – Specialist Care

Covered Health Services and Supplies rendered by a Specialty Care Physician, other than non-minor surgical procedures and related supplies, and received in the Physician's office. A Specialty Care Physician is other than a Covered Person's primary care physician, or covering physician of similar medical practices.

- This Copayment does not apply to the prenatal and postnatal office visits to the Network obstetrician/gynecologist who is primarily responsible for maternity care.

Network
No

Please refer to the insert Schedule-of-Benefits

Non-Network
No

Please refer to the insert Schedule-of-Benefits

23. Private Duty Nursing

Covered Health Services for private duty nursing care received in he home when provided by a licensed nurse (R.N., L.P.N., or L.V.N.).

Network
No

Please refer to the insert Schedule-of-Benefits

Non-Network
No

Please refer to the insert Schedule-of-

24. Professional Fees for Surgical and Medical Services

Professional fees for non-minor surgical procedures received in any location and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility.

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

Network

No

Please refer to the insert Schedule-of-Benefits

Non-Network

No

Please refer to the insert Schedule-of-Benefits

25. Prosthetic Devices

Prosthetic devices that replace a limb or body part including:

- Artificial limbs.
- Artificial eyes.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 2007.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.

Network

No

Please refer to the insert Schedule-of-Benefits

Non-Network

No

Please refer to the insert Schedule-of-

The prosthetic device must be ordered or provided by, or under the direction of a Physician. We provide Benefits for a single purchase, including repairs, of a type of prosthetic device. Benefits are provided for the replacement of each type of prosthetic device every five calendar years.

Benefits

26. Reconstructive Procedures

Reconstructive procedures - services are considered reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part. By improving or restoring physiologic function it is meant that the target 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.

Cosmetic Procedures - services are considered Cosmetic Procedures when they improve appearance without making an organ or body part work better. The fact that a person may suffer psychological consequences from the impairment does not classify surgery and other procedures done to relieve such consequences as a reconstructive procedure. Reshaping a nose with a prominent "bump" would be a good example of a Cosmetic Procedure because appearance would be improved, but there would be no effect on function like breathing. This Plan does not provide Benefits for Cosmetic Procedures.

Some services are considered cosmetic in some circumstances and reconstructive in others. This means that there may be situations in which the primary purpose of the service is to make a body part work better, whereas in other situations, the purpose would be to improve appearance and function (such as

Network
No

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

Non-Network
Yes

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

vision) is not affected. A good example is upper eyelid surgery. At times, this procedure will improve vision, while on other occasions improvement in appearance is the primary purpose of the procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Other services mandated by the Women's Health and Cancer Rights Act of 2007, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any Covered Health Service. You can contact the Claims Administrator at the telephone number on your identification (ID) card for more information about Benefits for mastectomy-related services.

Notify the Claims Administrator

Please remember that for Non-Network Benefits you should notify the Claims Administrator five business days before receiving services. If you don't notify the Claims Administrator, Benefits otherwise available will be subject to a reduction of $250

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27. Rehabilitation Services - Outpatient Therapy

Network
No

Please refer to the insert Schedule-of-Benefits

Short-term outpatient rehabilitation services for:

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

- Cardiac rehabilitation therapy.

Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Annual maximum is 45 visits for any combination of Rehabilitation Services and Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy.	***Non-Network*** Yes for more than 20 visits	Please refer to the insert Schedule-of-Benefits

The Plan gives the Claims Administrator the right to exclude from coverage rehabilitation services that are not expected to result in significant physical improvement in your condition within two months of the start of treatment. In addition, the Claims Administrator has the right to deny Benefits if treatment ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.

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

Please note that the Plan excludes any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

Notify the Claims Administrator

Please remember that you must notify the Claims Administrator prior to receiving the 21 visit from a Non-Network provider. If you don't notify the Claims

Administrator, Benefits otherwise available will be subject to a reduction of $250.

28. 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 (a room with two or more beds).

Any combination of Network and Non-Network Benefits is limited to 120 days per Calendar year. (Inpatient Rehabilitative Services limited to 30 days per Calendar year)

Please note that, in general, the intent of skilled nursing is to provide Benefits for Covered Persons who are convalescing from an Injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation and facility services which are less than those of a general acute Hospital but greater than those available in the home setting.

The Covered Person is expected to improve to a predictable level of recovery.

Benefits are available when skilled nursing and/or rehabilitation services are needed on a daily basis. Accordingly, Benefits are NOT available when these services are required intermittently (such as physical therapy three times a week).

Network
No

Please refer to the insert Schedule-of-Benefits

Benefits are NOT available for custodial, domiciliary or maintenance care (including administration of enteral feeds) which, even if it is ordered by a Physician, is primarily for the purpose of meeting personal needs of the Covered Person or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

(Custodial, domiciliary or maintenance care may be provided by persons without special skill or training. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, eating and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs.)

Notify the Claims Administrator

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

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

If you don't notify the Claims Administrator, Benefits will be reduced by $250.

Non-Network
Yes

Please refer to the insert Schedule-of-Benefits

29. Spinal Treatment, Chiropractic and

Network
No

Same as PCP

Description	Must You Notify the Claims Administrator?	Your Payment
Osteopathic Manipulative Therapy Benefits for Spinal Treatment include chiropractic and osteopathic manipulative therapy. Benefits for Spinal Treatment when provided by a Spinal Treatment provider in the provider's office. Benefits include diagnosis and related services and are limited to one visit and treatment per day. Annual maximum is 45 visits for **any combination** of Rehabilitation Services and Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy**.** Please note that the Plan excludes any type of therapy, service or supply including, but not limited to spinal manipulations by a chiropractor or other Physician for the treatment of a condition when the therapy, service or supply ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring. **Notify the Claims Administrator** Please remember that you must notify the Claims Administrator prior to receiving the 21st visit from a Non-Network provider. If you don't notify the Claims Administrator, Benefits otherwise available will be subject to a reduction of $250.	*Non-Network* Yes, approval required for more than 20 visits	office visit Same as PCP office visit
30. Transplantation Services Covered Health Services for the following organ and tissue transplants when ordered by a Physician. For the highest level	*Network* Yes	Covered same as Physician's

of Benefits, services must be received at a Designated United Resource Network Facility. Benefits are available for the transplants listed below when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational Service or an Unproven Service. Claims Administrator notification is required for all transplant services. The Copayment and Annual Deductible will not apply to Network Benefits when a transplant listed below is received at a Designated United Resource Network Facility. The services described under **Transportation and Lodging** below are Covered Health Services **ONLY** in connection with a transplant received at a Designated United Resource Network Facility. • Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered 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. If a separate charge is made for bone marrow/stem cell search, a Maximum Benefit of $50,000 is payable for all charges made in connection with the search. • Heart transplants. • Heart/lung transplants. • Lung transplants. • Kidney transplants.	 ***Non-Network***	Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices. Not Covered.

- Kidney/pancreas transplants.
- Liver transplants.
- Liver/small bowel transplants.
- Pancreas transplants.
- Small bowel transplants/Stem Cell Transplants.
- Other transplant procedures when the Plan determines that it is an Eligible Expense to perform the procedure at a Designated Transplant Facility.

Benefits for cornea transplants that are provided by a Physician at a Hospital are paid as if the transplant was received at a Designated United Resource Network Facility. We do not require that cornea transplants be performed at a Designated United Resource Network Facility in order for you to receive the highest level of Benefits.

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be a proven procedure for the involved diagnoses.

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

Transportation and Lodging

The Claims Administrator will assist the patient and family with travel and lodging arrangements only when services are received from a Designated United Resource Network Facility. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/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 $50 for one person or up to $100 for two people.
- Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Designated United Resource Network Facility.
- If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the $100 per diem rate.

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.

Notify the Claims Administrator

For Network Benefits you or your Physician must notify the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you do not notify the Claims Administrator, you will be responsible for paying all charges and Network Benefits will not be paid.

31. Therapeutic Services

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

- cancer chemotherapy
- intravenous infusion therapy

Benefits under this section include only the facility charge and the charge for required services, supplies and equipment.

Network

No

Please refer to the insert Schedule-of-Benefits

Non-Network

Yes

Please refer to

Benefits for the professional fees related to therapeutic services are described under *Professional Fees for Surgical and Medical Services* above. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.		the insert Schedule-of-Benefits

32. Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this section.	***Network*** No	Please refer to Schedule-of-Benefits
	Non-Network No	Please refer to Schedule-of-Benefits

Section 2: What's Not Covered--Exclusions

This section contains information about:

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

How We Use Headings in this Section

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

Plan Exclusions

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

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

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

A. Alternative Treatments

1. Acupressure.
2. Aromatherapy.
3. Hypnotism.
4. Massage Therapy.
5. Rolfing.
6. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
7. Services received by a naturopath.
8. Herbal medicine, holistic or homeopathic care, including drugs.

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. Home remodeling to accommodate a health need (such as, but not limited to, ramps and swimming pools).

C. Dental

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

D. Drugs

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

E. Experimental or Investigational Services or Unproven Services

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

F. Foot Care

1. Except when needed for severe systemic disease:

- Routine foot care (including the cutting or removal of corns and calluses).
- Nail trimming, cutting, or debriding.

2. Hygienic and preventive maintenance foot care. Examples include the following:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.
   - Other services that are performed when there is not a localized illness, Injury or symptom involving the foot.
3. Treatment of flat feet.
4. Treatment of subluxation of the foot.
5. Shoe orthotics except for custom molded shoe inserts prescribed to treat a disease or illness of the foot.

G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Prescribed or non-prescribed medical supplies. Examples include:
   - Elastic stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Syringes.
   - Diabetic test strips.
3. Orthotic appliances that straighten or re-shape a body part (including some types of braces).
4. Tubings, nasal cannulas, connectors and masks are not covered except when used with Durable Medical Equipment (as described in Section 1: What's Covered--Benefits).

H. Mental Health/Substance Abuse

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

reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following:

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

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

8. Pastoral counselors.
9. Treatment provided in connection with autism.
10. Treatment provided in connection with tobacco dependency.
11. Routine use of psychological testing without specific authorization.

I. Nutrition

1. Megavitamin and nutrition based therapy.
2. Except as described in (Section 1: What's Covered -- Benefits) under *Nutritional Counseling,* nutritional counseling for either individuals or groups, including weight loss programs, health clubs and spa programs.
3. Enteral feedings and other nutritional and electrolyte formulas, including infant formula, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins, and oral minerals except when sole source of nutrition.

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. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.
   Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in (Section 1: What's Covered--Benefits).
3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.

4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
5. Wigs except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury.
6. Services received from a personal trainer.
7. Liposuction.

K. Providers

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

   This exclusion does not apply to mammography testing.

L. Reproduction

1. Health services and associated expenses for infertility treatments.
2. Surrogate parenting.
3. The reversal of voluntary sterilization.
4. Fees or direct payment to a donor for sperm or ovum donations.
5. Monthly fees for maintenance and/or storage of frozen embryos.
6. Contraceptive supplies and services.

M. Services Provided under Another Plan

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

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

N. Transplants

1. Health services for organ and tissue transplants, except those described in (Section 1: What's Covered--Benefits).
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan).
3. Health services for transplants involving mechanical or animal organs.
4. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Health Services* in (Section 1: What's Covered--Benefits), unless determined by the Claims Administrator to be a proven procedure for the involved diagnoses.

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 services rendered at United Resource Networks participating programs or Designated Facilities may be reimbursed at our discretion.

P. Vision

1. Purchase cost of eye glasses or contact lenses.
2. Fitting charge for eye glasses or contact lenses.
3. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as radial keratotomy, laser, and other refractive eye surgery.

Q. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in (Section 10: Glossary of Defined Terms).
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
   - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders.
   - Conducted for purposes of medical research.
   - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
4. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.

6. In the event that a Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments and/or Annual Deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered to be medical or dental in nature, including oral appliances.
9. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly.
10. 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.
11. Non-surgical treatment of obesity, including morbid obesity.
12. Growth hormone therapy (except as approved by Personal Health Services for certain limited conditions).
13. Sex transformation operations.
14. Custodial Care.
15. Domiciliary care.
16. Private duty nursing received on an inpatient basis.
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. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
23. Appliances for snoring.
24. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
25. Any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply or equipment.
26. Any charge for services, supplies or equipment advertised by the provider as free.
27. Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency.
28. Any charges prohibited by federal anti-kickback or self-referral statutes.
29. Chelation therapy, except to treat heavy metal poisoning.
30. Any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services.
31. Outpatient rehabilitation services, spinal treatment or supplies including, but not limited to spinal manipulations by a chiropractor or other doctor, for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

32. Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness, such as asthma or allergies.
33. Speech therapy to treat stuttering, stammering, or other articulation disorders.

Section 3: Description of Network and Non-Network Benefits

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

Network Benefits

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

- Provided by or under the direction of a Network Physician or other Network provider in the Physician's office or at a Network or Non-Network facility.
- Emergency Health Services.
- Approved in advance by the Claims Administrator if a Network Provider is not within 30 miles.

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

Comparison of Network and Non-Network Benefits

	Network	Non-Network
Benefits	A higher level of Benefits means less cost to you. See (Section 1: What's Covered—Benefits).	A lower level of Benefits means more cost to you. See (Section 1: What's Covered—Benefits).
Who Should Notify the Claims Administrator	Network providers generally handle notification for you. See (Section 1: What's Covered—Benefits), under the *Must You Notify The Claims Administrator?* column.	You must notify the Claims Administrator for certain Covered Health Services. Failure to notify results in reduced Benefits or no Benefits. See (Section 1: What's Covered—Benefits), under the *Must You Notify The Claims Administrator?* column.
Who Should File Claims	Not required. We pay Network providers directly.	You must file claims. See (Section 5: How to File a

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

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

Provider Network

The Claims Administrator or its affiliate arranges for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees or employees of the Claims Administrator. It is your responsibility to select your provider.

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

You may request a directory of Network providers at no cost to you. Provider directories are always available on www.myuhc.com. However, before obtaining services you should always verify the Network status of a provider. A provider's status may change. You are responsible for verifying a provider's Network status prior to receiving services, even when you are referred by another Network provider. You can verify the provider's status, request a provider directory, or

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

request additional available information about a provider by calling the Claims Administrator.

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

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

Claims Administrator

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

Designated United Resource Network Facilities and Other Providers

If you have a medical condition that the Claims Administrator believes needs special services, they may direct you to a

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

Designated United Resource Network Facility or other provider chosen by them. If you require certain complex Covered Health Services for which expertise is limited, the Claims Administrator may direct you to a Non-Network facility or provider.

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

UnitedHealth Premium℠ Program

The UnitedHealth Premium Program identifies Network Physicians and facilities currently in UnitedHealthcare's Network that meet or exceed UnitedHealth Premium program quality and efficiency criteria. You may obtain additional information regarding the UnitedHealth Premium program online at www.myuhc.com or by calling the number on the back of your ID card.

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.

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

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.

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 which are either of the following:

- Provided by Non-Network providers.
- Provided under the direction of a Non-Network Physician, at a Network or Non-Network facility or program. Covered Health Services provided by any of the listed Network facilities or programs (Hospital, Alternate Facility, Home Health Agency, Skilled Nursing Facility, Inpatient

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

Rehabilitation Facility, or Hospice program) are payable as Non-Network Benefits if the services are provided through a Non-Network Physician.

Notification Requirement

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

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

Claims Administrator

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

Emergency Health Services

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

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

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

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

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

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

Section 4: When Coverage Begins

This section includes information about:

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

How to Enroll

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

If You Are Hospitalized When Your Coverage Begins

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

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

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

You should notify the Claims Administrator within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network Providers.

If You Are Eligible for Medicare

You will be responsible for the costs that Medicare would have paid if you are eligible for Medicare but do not enroll in and maintain coverage under both Medicare Part A and Part B.

If you are enrolled in a Medicare Advantage (Medicare Part C) plan, you will be responsible for any additional costs or reduced benefits that result if you fail to follow the requirements of the Medicare Advantage plan. Please see *Medicare Eligibility* in (Section 9: General Legal Provisions) for more information about how Medicare may affect your Benefits.

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

Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Eligible Person	Eligible Person usually refers to a Participant 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, see (Section 10: Glossary of Defined Terms). If both spouses are Eligible Persons of the Plan Sponsor, each may enroll as a Participant or be covered as an Enrolled Dependent of the other, but not both. Except as we have described in (Section 4: When Coverage Begins), Eligible Persons may not enroll without our written permission.	The Staff Health Plan Administrator determines who is eligible to enroll under the Plan. Please refer to your Staff Health Plan summary plan description (SPD) for details.
Dependent	Dependent generally refers to the Participant's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see your Staff Helath Plan SPD. Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan.	The Staff Health Plan Administrator determines who qualifies as a Dependent.

When to Enroll and When Coverage Begins

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

When to Enroll	Who Can Enroll	Begin Date
		to the Plan Administrator for Coverage.

Adding New Dependents

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

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

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

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because required contributions 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.
- For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true:
  - — The Eligible Person and/or Dependent had existing health coverage under another plan
    at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and
  - — Coverage under the prior plan ended because of any of the following:
    - ♦ Loss of eligibility (including, without limitation, legal separation, divorce or death).
    - ♦ The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.

Event Takes Place (for example, a birth or marriage). Coverage begins on the date of the event if the Staff Health Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the event.

Missed Initial Enrollment Period or Open Enrollment Period. Coverage begins on the day immediately following the day coverage under the prior plan ends if theStaff Health Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the date coverage under the prior plan ended.

- In the case of COBRA continuation coverage, the coverage ended.
- The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.
- The Plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
- An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.

Section 5: How to File a Claim

This section provides you with information about:

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

If You Receive Covered Health Services from a Network Provider

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

Filing a Claim for Benefits

When you receive Covered Health Services from a Non-Network provider, you are responsible for requesting payment from us through the Claims Administrator. You must file the

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

claim in a format that contains all of the information required, as described below.

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

If your LTF withdraws from the BAC HCPC you must submit a request for payment of Benefits within one year after the date of service and within 90 days of your LTFs withdrawal.

If the BAC HCPC changes Claim Administrators you must submit a request for payment of Benefits within one year after the date of service and within 6 months of the BAC HCPC change in Claims Administrators.

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

Required Information

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

A. The Participant's name and address.

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

B. The patient's name, age and relationship to the Participant.
C. The number stated on your ID card.
D. The name and address of the provider of the service(s).
E. A diagnosis from the Physician.
F. An itemized bill from your provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge.
G. The date the Injury or Sickness began.
H. A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

Payment of Benefits

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

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

The Claims Administrator will notify you if additional information is needed to process the claim. The Claims Administrator will pend your claim until all information is received.

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

Benefit Determinations

Once the Claims Administrator receives all of the needed information, and in the event the claim is denied, the Claims Administrator will notify you of the determination.

This notice will explain the reason for denial and provide the claim appeal procedures. If you filed the claim improperly or if additional information is needed to process the claim, the notice will describe how to correct the claim or the additional information needed.

Benefit Determinations

Post-Service Claims

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

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

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

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

Pre-Service Claims

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

Urgent Claims that Require Immediate Action

Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in

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

treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition could cause severe pain. In these situations:

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

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

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

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

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

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

Concurrent Care Claims

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

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

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

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

Section 6: Questions and Appeals

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

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

This section does not apply to questions or appeals regarding eligibility. If you have such a question or appeal, you should consult your LTF SPD.

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

What to Do First

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

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

contact Customer Service and later wish to request a formal appeal in writing, you should contact Customer Service and request an appeal. If you request a formal appeal, a Customer Service representative will provide you with the appropriate address of the Claims Administrator.

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

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

How to Appeal a Claim Decision

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

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

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

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

Appeal Process

The Claims Administrator will appoint a qualified individual to resolve or recommend the resolution of the appeal. If your complaint is related to clinical matters, the review will be done by a health care professional who was not involved in the initial determination with appropriate expertise in the field. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information.

Appeals Determinations

The Claims Administrator will send you written or electronic notification of its decision on non-urgent claims within 60 days of the receipt of all needed information.

However, if special circumstances require an extension of time to reach a final decision, written notice of the final decision will be sent as soon as possible following the expiration of the initial 60 day period, but no later than 120 days following receipt of the request for review of a denied claim or notice of a complaint or dispute. If special circumstances require such an extension of time, written notice of the extension shall be furnished to the complainant prior to the expiration of the initial 60 day period.

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

If you are still not satisfied with this decision, you have the right to take your appeal to the Plan Administrator. The Plan Administrator has the exclusive right to interpret and

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

administer the Plan, and these decisions are conclusive and binding.

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

Urgent Claim Appeals that Require Immediate Action

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

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

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

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

Voluntary External Review Program

If a final determination to deny Benefits is made, you may choose to participate in our voluntary external review program. This program only applies if the decision is based on either of the following:

- Clinical reasons.
- The exclusion for an Experimental or Investigational Service or an Unproven Service.

The external review program is not available if the coverage determinations are based on explicit Benefit exclusions or defined Benefit limits.

Contact the Claims Administrator at the telephone number shown on your ID card for more information on the voluntary external review program.

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

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

Section 7: Coordination of Benefits

This section provides you with information about:

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

Benefits When You Have Coverage under More than One Plan

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

When Coordination of Benefits Applies

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

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

The order of benefit determination rules described in this section determine which Coverage Plan will pay as the Primary Coverage Plan. The Primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some expenses. A Secondary Coverage Plan pays after the Primary Coverage Plan and may reduce the Benefits it pays. This is to prevent payments from all group Coverage Plans from exceeding 100 percent of the total Allowable Expense.

Definitions

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

1. "Coverage Plan" is any of the following that provides Benefits or services for medical care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.
   a. "Coverage Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; medical Benefits under group or individual automobile contracts; and Medicare or other governmental Benefits, as permitted by law.
   b. "Coverage Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; Benefits for non-medical components of group long-term care policies; Medicare supplement policies,

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

Medicaid policies and coverage under other governmental Plans, unless permitted by law.

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

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

   When this Coverage Plan is primary, its Benefits are determined before those of any other Coverage Plan and without considering any other Coverage Plan's Benefits. When this Coverage Plan is secondary, its Benefits are determined after those of another Coverage Plan and may be reduced because of the Primary Coverage Plan's Benefits.

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

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

   a. If a Covered Person is confined in a private Hospital room, the difference between the cost of a Semi-private Room in the Hospital and the private room, (unless the patient's stay in a private Hospital room is medically necessary in terms of generally accepted medical practice, or one of the Coverage Plans routinely provides coverage for Hospital private rooms) is not an Allowable Expense.
   b. If a person is covered by two or more Coverage Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.
   c. If a person is covered by two or more Coverage Plans that provide Benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
   d. If a person is covered by one Coverage Plan that calculates its Benefits or services on the basis of usual and customary fees and another Coverage Plan that provides its Benefits or services on the basis of negotiated fees, the Primary Coverage Plan's payment arrangements shall be the Allowable Expense for all Coverage Plans.
   e. The amount a benefit is reduced by the Primary Coverage Plan because a Covered Person does not comply with the Coverage Plan provisions is not an Allowable Expense. 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

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

a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.

5. "Closed Panel Plan" is a Coverage Plan that provides health Benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes Benefits for services provided by other providers, except in cases of Emergency or referral by a panel member.
6. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules

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

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

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

type coverages that are written in connection with a closed panel Coverage Plan to provide Non-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. This Plan will always be secondary to medical payment coverage or personal injury protection (PIP) coverage under any auto liability or no-fault insurance policy.
   2. Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a Dependent, for example as a Participant, 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 Participant); then the order of Benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as a Participant, member, subscriber or retiree is secondary and the other Coverage Plan is primary.
   3. 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:

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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 calendar years commencing after the Coverage Plan is given notice of the court decree.

c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of Benefits is:
1) The Coverage Plan of the custodial parent;
2) The Coverage Plan of the spouse of the custodial parent;
3) The Coverage Plan of the noncustodial parent; and then
4) The Coverage Plan of the spouse of the noncustodial parent.

4. Active or inactive Participant. The Coverage Plan that covers a person as a Participant who is neither laid off nor

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retired is primary. The same would hold true if a person is a Dependent of a person covered as a retiree and a Participant. 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(2).

5. 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 a Participant, 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.
6. Longer or shorter length of coverage. The Coverage Plan that covered the person as a Participant, member, subscriber or retiree longer is primary.
7. 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.
8. 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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Effect on the Benefits of this Plan

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

   1. Determine its obligation to pay or provide Benefits under its contract;
   2. Determine whether a benefit reserve has been recorded for the Covered Person; and
   3. Determine whether there are any unpaid Allowable Expenses during that claim determination period.

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

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

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

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

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

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

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

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

Payments Made

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

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

"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.

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

Section 8: When Coverage Ends

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

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

General Information about When Coverage Ends

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

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

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

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

An Enrolled Dependent's coverage ends on the date the Participant's coverage ends or sooner if the Participant chooses to end the Dependent's coverage or as otherwise set forth in this SPD.

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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
The Entire Plan Ends	Your coverage ends on the date the Plan ends. We are responsible for notifying you that your coverage has ended. You have six months to submit any claims. Claims still must be received within one year of the date of service.
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. Please refer to (Section 10: Glossary of Defined Terms) for a more complete definition of the terms "Eligible Person", "Participant," "Dependent" and "Enrolled Dependent."
Your LTF Withdraws from the BAC HCPC	Your coverage ends on the date your LTF's withdrawal from HCPC is effective. Your LTF is responsible for notifying you that your coverage has ended. You have 90 days to submit any claims. Your claims must still be received within one year of the date of service.

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. During the first two years the Plan is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Plan. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.
Material Violation	There was a material violation of the terms of the Plan.
Improper Use of ID Card	You permitted an unauthorized person to use your ID card, or you used another person's card.
Failure to Pay	You failed to pay a required contribution.
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, mental illness, or a physical handicap will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental retardation, mental illness, or physical handicap.
- Depends mainly on the 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 LTF Plan Administrator with proof of the child's incapacity and dependency within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before the LTF Plan Administrator agrees to this extension of coverage for the child, the LTF Plan 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. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

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

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.

Continuation of Coverage

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

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

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

Continuation Coverage under Federal Law (COBRA)

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

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

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

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

Qualifying Events for Continuation Coverage under COBRA

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

The qualifying events with respect to a Participant who is a Qualified Beneficiary are:

A. Termination of employment with a contributing employer to the LTF, us, for any reason other than gross misconduct*; and
B. Reduction in the Participant hours of employment.*

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

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

A. Termination of the Participant's employment (for reasons other than the Participant's gross misconduct)*; or
B. Reduction in the Participant's hours of employment*; or
C. Death of the Participant; or
D. Divorce or legal separation from the covered Participant; or
E. Loss of eligibility by an Enrolled Dependent who is a child; or
F. Entitlement of the Participant to Medicare benefits; or
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 LTF Plan Administrator within 60 days of the latest of the date of the Participant's divorce, legal separation or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent; the date the Qualified Beneficiary would lose coverage under the Plan; or the date on which the Qualified Beneficiary is informed of his or her obligation to provide notice and the procedures for providing such notice. A Participant or other Qualified

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

Beneficiary must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If the Participant or other Qualified Beneficiary fails to notify the LTF Plan Administrator of these events within the 60 day period, the LTF 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 LTF Plan Administrator within 60 days of the birth or adoption of a child.

* For some LTF's with Hours or Dollar Banks these may not be qualifying events.

Notification Requirements for Disability Determination or Change in Disability Status

The Participant or other Qualified Beneficiary must notify the LTF Plan Administrator as described under "COBRA Terminating Events" in this section.

The notice requirements will be satisfied by providing written notice to the LTF Plan Administrator at the address stated in Attachment II. The contents of the notice must be such that the Plan Administrator is able to determine the covered Participant and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

None of the 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 LTF Plan Administrator, the Qualified Beneficiary shall receive the continuation coverage

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

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

The Qualified Beneficiary's initial premium due to the LTF 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 a federal law called 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 should contact the LTF Plan Administrator for additional information. The Participant must contact the LTF Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Participant will lose his or her special COBRA rights. COBRA coverage

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

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.

COBRA Terminating Events

COBRA continuation coverage under the Plan will end on the earliest of the following dates:

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

   If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at any time within the first 60 days of continuation coverage for qualifying event A. 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: (i) notice of such 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 eighteen months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional eleven months; and (iii) if the Qualified Beneficiary 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

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

   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, 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:

   i. Eighteen months from the date of the Participant's Medicare entitlement; or

   ii. 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. With respect to Qualified Beneficiaries, and to the extent that the Participant became entitled to Medicare subsequent to the qualifying event:

   i. Thirty-six months from the date of the Participant's termination of employment or work hours being reduced (first qualifying event), if:

      a. the Participant's Medicare entitlement occurs within the eighteen month continuation period; and

      b. if absent the first qualifying event, the Medicare entitlement would have resulted in a loss of coverage

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

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 preexisting condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.
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 right column on this page.

Uniformed Services Employment and Reemployment Rights Act

A Participant who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Participant and the Participant'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 pursuant to continue coverage pursuant to the USERRA, Participants may elect to continue coverage under the Plan by notifying the LTF Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the LTF Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period of time less than 31 days, the Participant may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

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

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

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

Regardless of whether a Participant continues health coverage, if the Participant returns to a position of employment, the Participant's health coverage and that of the Participant's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant'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 the LTF Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

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

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Section 9: General Legal Provisions

This section provides you with information about:
- General legal provisions concerning your Plan.

Plan Document

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

Relationship with Providers

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

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

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

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

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

The LTF Plan Administrator is solely responsible for all of the following:

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

Your Relationship with Providers

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

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

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

Incentives to Providers

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

Examples of financial incentives for Network providers are:

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

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

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

Incentives to You

Sometimes the Claims Administrator may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact the Claims Administrator if you have any questions.

Rebates and Other Payments

We and the Claims Administrator may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. 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 Benefit Levels.

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.

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

- Make factual determinations related to the Plan and its Benefits.

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

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

Administrative Services

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

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

or applicable state law provisions not otherwise preempted by ERISA (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 (in the case of a change or Amendment) or in a written resolution (in the case of a termination), whether prospective or retroactive, to the Plan, in accordance with the procedures established by us. Covered Persons will receive notice of any material modification to the Plan. No one has the authority to make any oral modification to the SPD.

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to Benefits. These errors include, but are not limited to, providing misinformation on eligibility or Benefit coverages or entitlements. The terms of this Plan may not be amended by oral statements made by the Plan Sponsor, the Plan Administrative Committee, the Claims Administrator, or any other person. In the event an oral statement conflicts with any term of the Plan, the Plan terms will control. It is your responsibility to confirm the accuracy of statements made by us or our designees, including the Claims Administrator, in accordance with the terms of this SPD and other Plan documents.

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Information and Records

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

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

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

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

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

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

Examination of Covered Persons

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

Workers' Compensation not Affected

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

Medicare Eligibility

Benefits under the Plan may be 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. Please refer to your LTF SPD regarding Plan Eligibility.

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

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

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, the Plan shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable

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value of any services and Benefits the Plan provided to Covered Persons, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Summary Plan Description, the Plan shall also have an independent right to be reimbursed by Covered Persons for the reasonable value of any services and Benefits the Plan provides to Covered Persons, from any or all of the following listed below.

- Third parties, including any person alleged to have caused a Covered Person to suffer injuries or damages.
- Any person or entity who is or may be obligated to provide Benefits or payments to a Covered Person, including Benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to a Covered Person on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties".

Covered Persons agree as follows:

- That a Covered Person will cooperate with the Plan in a timely manner in protecting our legal and equitable rights to subrogation and reimbursement, including, but not limited to:

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- — providing any relevant information requested by the Plan,
- — signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim,
- — responding to requests for information about any accident or injuries,
- — appearing at depositions and in court, and
- — obtaining the consent of the Plan or its agents before releasing any party from liability or payment of medical expenses.

- That failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits and/or the institution of legal action against a Covered Person.

- That the Plan has the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- That no court costs or attorneys' fees may be deducted from the Plan's recovery without the Plan's express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and the Plan is not required to participate in or pay court costs or attorneys' fees to the attorney hired by a Covered Person to pursue his or her damage/personal injury claim.

- That regardless of whether a Covered Person has been fully compensated or made whole, the Plan may collect from Covered Persons the proceeds of any full or partial recovery that a Covered Person or his or her legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment. The proceeds available for collection shall include, but not be limited to any and all amounts earmarked as non-economic damage settlement or judgment.

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- That benefits paid by the Plan may also be considered to be benefits advanced.

- That Covered Persons agree that if they receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, the Covered Person will serve as a constructive trustee over the funds and failure to hold such funds in trust will be deemed as a breach of the Covered Person's duties hereunder.

- That Covered Persons or an authorized agent, such as the Covered Person's attorney, must hold any funds received from any potentially responsible party that are due and owed to the Plan, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the institution of legal action against the Covered Person.

- That the Plan shall be entitled to recover reasonable attorney fees from Covered Persons incurred in collecting from the Covered Person any funds held by the Covered Person that he or she recovered from any Third Party.

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- That the Plan may set off from any future benefits otherwise allowed by the Plan the value of benefits paid or advanced under this section to the extent not recovered by the Plan.
- That Covered Persons will neither accept any settlement that does not fully compensate or reimburse the Plan without the Plan's written approval, nor will the Covered Person do anything to prejudice the Plan's rights under this section.
- That Covered Persons will assign to the Plan all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits the Plan provided, plus reasonable costs of collection.
- That the Plan's rights will be considered as the first priority claim against Third Parties, including tortfeasors for whom Covered Persons are seeking recovery, to be paid before any other of the Covered Person's claims are paid.
- That the Plan' rights will not be reduced due to the Covered Person's own negligence.
- That the Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in the Covered Person's name, which does not obligate the Plan in any way to pay the Covered Person part of any recovery the Plan might obtain.
- That the Plan shall not be obligated in any way to pursue this right independently or on behalf of the Covered Person.

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

- That if the injury or condition giving rise to subrogation or reimbursement involves a minor child, this section applies to the parents or guardian of the minor child.
- That if the injury or condition giving rise to subrogation or reimbursement involves the wrongful death of a Plan beneficiary, this section applies to the personal representative of the deceased Plan beneficiary.

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.

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

Limitation of Action

You cannot bring any legal action against us or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in (Section 5: How to File a Claim) and all required reviews of your claim have been completed. 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.

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

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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.

Addendum - any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall 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 shall be controlling.

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

- Pre-scheduled surgical services.
- Emergency Health Services.

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

- Pre-scheduled rehabilitative, laboratory or diagnostic services.

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

Ambulatory Surgical Center Service - are medical facilities that specialize in elective same-day or outpatient surgical procedures. They do not offer emergency care. Ambulatory surgical centers are also known as surgicenters.

Amendment - any attached written description of additional or revised provisions or Benefits to the Plan. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

Annual Deductible - the amount you must pay for Covered Health Services in a Calendar year before we will begin paying for Benefits 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 below.

Bariatric Procedures – Surgical treatment of morbid obesity received on an inpatient basis in a Hospital.

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 applicable Riders and Amendments.

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

BMI - a measure used in obesity risk assessment to determine the degree of obesity by approximating the measure of total body fat as compared with the assessment of body weight alone. Also referred to as Body Mass Index.

Claims Administrator - the company, or its affiliate, that provides certain claim administration services for the Plan.

Coinsurance - Coinsurance is the portion of medical costs that are shared by both the insured (the patient) and the insurer.

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

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

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

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

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

Covered Health Services must be provided:

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

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

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

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; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

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

Dependent – Please refer to your LTF SPD for this definition. If your LTF includes coverage for a handicapped Child, please refer to the definition of a Handicapped Child in Section 8.

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

Diagnostic Services – means procedures ordered by a physician or other professional provider to determine a definite condition or disease.

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

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

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

Eligible Expenses - Eligible Expenses for Covered Health Services, incurred while the Plan is in effect, 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.
  - When Covered Health Services are received from non-Network providers as a result of an Emergency or as otherwise arranged by the Claims Administrator, Eligible Expenses are the fee(s) that are negotiated with the non-Network provider.
- For Non-Network Benefits, Eligible Expenses are determined by either:
  - calculating Eligible Expenses based on available data resources of competitive fees in that geographic area, or
  - applying the negotiated rates agreed to by the non-Network provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors.

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

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

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

Eligible Person - A person employed by an employer contributing to the LTF and who has met the eligibility requirements prescribed by the LTF.

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

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

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

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

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug

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

therapies or devices that, at the time a determination is made regarding coverage in a particular case, are determined to be any of the following:

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

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

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

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

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

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

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

Initial Enrollment Period - the initial period of time, as determined by the LTF Plan Administrator, during which Eligible Persons may enroll themselves and their Dependents under the Plan.

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

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

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

Laboratory Test – medical procedure that involves testing a sample of blood, urine, or other substance from the body. Tests can help determine a diagnosis, plan treatment, check to see if treatment is working, or monitor the disease over time.

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

LTF - is your Local Trust Fund.

LTF Plan Administrator - is your Local Trust Fund Trustees or their designee as that term is defined under ERISA.

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

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

Medicare Advantage – Medicare Part C

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 Abuse Designee - the organization or individual, designated by us, 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 the American Psychiatric Association, unless those services are specifically excluded under the Plan.

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

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

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

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

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

Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Plan. The LTF Plan Administrator will determine the period of time that is the Open Enrollment Period.

Out-of-Pocket Maximum - the maximum amount you pay out-of-pocket every calendar year after the Annual Deductible is met. Neither your Annual Deductible nor any Copayments you

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

make will count toward satisfying your Out-of-Pocket Maximum. If you use both Network Benefits and Non-Network Benefits, one integrated Out-of-Pocket Maximum applies. Depending on the geographic area and the service you receive, you may have access to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, your Coinsurance for Non-Network Benefits will remain the same, however the total amount that you owe may be less than if you received services from other non-Network providers because the Eligible Expenses may be a lesser amount. Once you reach the Out-of-Pocket Maximum, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that calendar year.

The following costs will never apply to the Out-of-Pocket Maximum:

- Any charges for non-Covered Health Services.
- The amount of any reduced Benefits if you don't notify the Claims Administrator as described in (Section 1: What's Covered--Benefits) under the *Must You Notify The Claims Administrator*? column.
- Charges that exceed Eligible Expenses.

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.

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

Claims Administrator - a program provided by the Claims Administrator designed to encourage an efficient system of care for Covered Persons by identifying and addressing possible unmet covered health care needs.

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

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

Physician – Primary Care Physician : General Practictioner, Pediatricion & Family Doctors

Physician – Specialty Care Physician : Any provider not consider a Primary Care Physician.

Plan – Choice/Choice Plus Plan for Bricklayers and Allied Craftworkers Health Care Purchasing Coalition.

Plan Administrator - is the Bricklayers and Allied Craftworkers Health Care Purchasing Coalition or its designee as that term is defined under ERISA.

Plan Sponsor - Bricklayers and Allied Craftworkers Health Care Purchasing Coalition. References to "we", "us", and "our" throughout the SPD refer to the Plan Sponsor.

Pregnancy - includes all of the following:

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

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

Preventive Care - medical services aimed at early detection and intervention. Focuses on wellness, health promotion, and other activities that reduce the likelihood of illness or Injury.

Primary Coverage Plan – Members Primary Benefits plan that pays first.

Qualified Beneficiary - A Qualified Beneficiary is any of the following persons who was covered under the Plan on the day before a qualifying event:

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

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

Secondary Coverage Plan - Pays after the Primary Coverage Plan and may reduce the Benefits it pays. This is to prevent

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

payments from all group Coverage Plans from exceeding 100 percent of the total Allowable Expense.

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

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD does not include Mental Illness or substance 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.

Specialist - 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.

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

Substance Abuse Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American

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

Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

Therapeutic Services - are therapies generally prescribed by a physician to rehabilitate or treat a condition related to a members developmental disability.

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

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

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

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

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

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

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

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

Riders, Amendments, Notices

UnitedHealth Allies Addendum

Attachment I

Attachment II

UnitedHealth Allies Addendum

Introduction

This Addendum to the Summary Plan Description provides discounts for select non-Covered Health Services from Physicians and health care professionals.

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

NOTE: 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 (Section 1: What's Covered -- Benefits) when a benefit is available.

What is UnitedHealth Allies?

UnitedHealth Allies is a health value program that offers savings on products and services that are **not** Covered Health Services under your health insurance plan.

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

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 you and your Dependents as defined in the Summary Plan Description (Section 10: Glossary of Defined Terms).

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.

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

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.

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

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

Attachment I

Women's Health and Cancer Rights Act of 2007

As required by the Women's Health and Cancer Rights Act of 2007, 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.

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

Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Group health Plans and health insurance issuers generally may not, under Federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less 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).

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

Attachment II

Summary Plan Description

Name of Plan: Bricklayers and Allied Craftworkers Health Care Purchasing Coalition

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

Plan Administrator – Medical Plan
Bricklayers and Allied Craftworkers Health Care Purchasing Coalition or designee
620 F Street NW
Washington, DC 20004
1 (888) 880-8222

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

Employer Identification Number (EIN):

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

52-6397805

IRS Plan Number: 501

Effective Date of SPD: 04/01/2008

Type of Plan: Group health care coverage plan

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

LTF Plan Administrator
Please refer to the Schedule-of-Benefits insert.

Plan Administrator
Bricklayers and Allied Craftworkers Health Care Purchasing Coalition, 620 F Street, NW, Washington, DC 20004
1 (888) 880-8222

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

UnitedHealthcare
450 Columbus Boulevard
Hartford, CT 06150

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

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

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

Person designated as agent for service of legal process: Service of process may also be made upon the Plan Administrator.

Source of contributions under the Plan: The Plan is funded through payments from LTF's which are in turn derived from contributions to the LTF's pursuant to collective bargaining agreements.

Method of calculating the amount of contribution: LTF - required payments to the Plan Sponsor are the LTF's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required LTF payments which are subject to change from time to time by the Plan Sponsor.

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

Date of the end of the year for purposes of maintaining Plan's fiscal records: Calendar year shall be a twelve month period ending December 31.

Determinations of Qualified Medical Child Support Orders.

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

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

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

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

Participant's rights under the Employee Retirement Income Security Act of 1974 (ERISA) and the procedures to be followed in regard to denied claims or other complaints relating to the Plan are set forth in the body of this Summary Plan Description.

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

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

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health Plan, if you have creditable coverage from another group health Plan. You should be provided a certificate of creditable coverage in writing, free of charge, from your group health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. You may request a certificate of creditable coverage by contacting the Plan Administrator. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who

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

operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court after all required reviews of your claim have been completed. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal

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

court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

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