Benefit Program Summary

Select EPO Plan

for

LANS

Group Number: 704121

Effective Date: June 1, 2008

IMPORTANT

This is a summary of highlights of the above-named Benefit Program, a component of the LANS Welfare Benefit Plan for Employees, ERISA Plan 501 and the LANS Welfare Benefit Plan for Retirees, ERISA Plan 502 (each a "Plan"). Receipt of this document and/or your participation in a Plan and any benefit programs under a Plan do not guarantee your employment or any rights or benefits under a Plan. LANS reserves the right to amend or terminate each Plan or any benefit program(s) under a Plan at any time. Each Plan and the benefit programs referred to in this summary are governed by a Federal law (known as ERISA), which provides rights and protections to Plan participants and beneficiaries.

For more information on LANS benefit programs, see the LANS Welfare Benefit Plan for Employees Summary Plan Description or the LANS Welfare Benefit Plan for Retirees Summary Plan Description, as applicable, available from the Los Alamos National Laboratory (LANL) Benefits Office at (877) 667-1806 or (505) 667-1806.

This is an EXCLUSIVE PROVIDER ORGANIZATION (EPO) plan.

This means: YOU MUST OBTAIN SERVICES FROM A UHC NETWORK PROVIDER OR NO BENEFITS WILL BE PAID FROM THE PLAN UNLESS THE CHARGES RESULT FROM A TRUE EMERGENCY.

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Introduction

We are pleased to provide you with this Benefit Program Summary. This Benefit Program Summary describes your Benefits, as well as your rights and responsibilities, under the Benefit Program.

In addition to the information contained in this Benefit Program Summary, the LANS Welfare Benefit Plan for Employees Summary Plan Description and the LANS Welfare Benefit Plan for Retirees Summary Plan Description contain important information about your LANS welfare benefits. This Benefit Program is a part of the LANS Summary Plan Description ("SPD"). The LANS SPD applicable to you depends on whether you are an employee or a retiree and is referred to in this Benefit Program Summary as "your LANS SPD."

For additional information:

For Employees:

Los Alamos National Laboratory (LANL)

LANL Benefits Office

P.O. Box 1663, Mail Stop P280

Los Alamos, NM 87544
(877) 667-1806 or (505) 667-1806
e-mail: **benefits@lanl.gov**
LANL Benefits Website for Employees:
http://int.lanl.gov/worklife/benefits/

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For Retirees:

Customer Care Center

(866) 934-1200

www.ybr.com/benefits/lanl
LANL Benefits Website for Retirees:
http://www.lanl.gov/worklife/benefits/retirees/

How to Use this Document

We encourage you to read your Benefit Program Summary and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this Benefit Program Summary 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 Benefit Program Summary 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 Benefit Program Summary 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 Benefit Program Summary and any attachments for your future reference.

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

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Providers are responsible for notifying Care Coordination[SM] about certain services and procedures. Your Primary Physician is responsible for coordinating your care from specialists and facilities. For more information, please read (Section 3: Obtaining Benefits).

Information About Defined Terms

Because this Benefit Program Summary 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: Glossary of Defined Terms) as you read this document to have a clearer understanding of your Benefit Program Summary.

When we use the words "we," "us," and "our" in this document, we are referring to the Benefit Program. 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).

LANS is the Plan Sponsor.

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Your Contribution to the Benefit Costs

The Benefit Program may require the Employee to contribute to the cost of coverage. Contact your Benefits representative for information about any part of this cost you may be responsible for paying.

Customer Service and Claims Submittal

Your United HealthCare ID card lists the toll-free number for Customer Service, who you contact for questions regarding:

- Coverage, benefits or instructions on processes to follow.
- Care notification by your provider.
- Care Coordination[SM].
- Claims payment.
- Network providers.

Much of this information is available on www.myuhc.com.

Claims Submittal Address:

United HealthCare Insurance Company

Attention: Claims
PO Box 30555
Salt Lake City, Utah 84130-0550

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Requests for Review of Denied Claims and Notice of Complaints:

Name and Address For Submitting Requests:

United HealthCare Insurance Company

Attention: Appeals
PO Box 30432
Salt Lake City, Utah 84130-0432

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.

Section 1: Eligibility, Enrollment, Termination, and Plan Administration.

Please refer to your LANS SPD for important information.

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Section 1: What's Covered--Benefits

This section provides you with information about:

- Accessing Benefits.
- Copayments and Eligible Expenses.
- Annual Deductible, Out-of-Pocket Maximum and Maximum Plan Benefit.
- Covered Health Services. We pay Benefits for the Covered Health Services described in this section unless they are listed as not covered in (Section 2: What's Not Covered--Exclusions).
- Covered Health Services that require you or your provider to notify Care Coordination℠ before you receive them. In general, Network providers are responsible for notifying Care Coordination℠ before they provide certain health services to you.

Accessing Benefits

You must select a Primary Physician who will provide or coordinate all of the Covered Health Services you receive. For details, see (Section 3: Obtaining Benefits).

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers may have no way of

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knowing that you are enrolled under the Benefit Program. As a result, they may bill you for the entire cost of the services you receive.

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

- Covered Health Services are received while the Benefit Program 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 Benefit Program.

Copayment

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

Eligible Expenses

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

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

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

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

When you receive Covered Health Services from Network providers, you are not responsible for any difference between the Eligible Expenses and the amount the provider bills.

Notification Requirements

Prior Notification is required before you receive certain Covered Health Services. In general, Network providers are responsible for notifying Care Coordination[SM] before they provide these services to you.

Services and/or supplies for which you must provide prior notification appear in this section under the *Must You Notify Care Coordination[SM]?* column in the table labeled *Benefit Information*. Without notification, you will be responsible for paying all charges and no Benefits will be paid. The services and/or supplies requiring notification include but not limited to:

- Durable Medical Equipment over $500
- Orthotics
- Orthognathic Surgery
- Air Ambulance Non-Emergency
- Obesity Surgery
- TMJ inpatient services

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To notify Care Coordination[SM], call the telephone number on your ID card for Claims Administration.

We urge you to confirm with Care Coordination[SM] that the services you plan to receive are Covered Health Services, even if not indicated in the *Must You Notify Care Coordination[SM]?* 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.

You can reach Care Coordination[SM] by calling the toll-free number on your ID card.

Special Note Regarding Medicare

If you are enrolled for Medicare on a primary basis (Medicare pays before we pay Benefits under the Benefit Program), **the notification requirements described in this Benefit Program Summary do not apply to you**. Since Medicare is the primary payor, we will pay as secondary payor as described in (Section 7: Coordination of Benefits). You are not required to notify Care Coordination[SM] before receiving Covered Health Services when Medicare is the primary payor.

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Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services before you are eligible to receive Benefits. For a complete definition of Annual Deductible, see (Section 10: Glossary of Defined Terms).	$150 per Covered Person per calendar year, not to exceed $450 for all Covered Persons in a family.
Out-of-Pocket Maximum	The maximum you pay, out of your pocket, in a calendar year for Copayments. For a complete definition of Out-of-Pocket Maximum, see (Section 10: Glossary of Defined Terms).	$2,000 per Covered Person per calendar year, not to exceed $6,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible.
Maximum Plan Benefit	The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Benefit Program.	No Maximum Plan Benefit.

Benefit Information

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
1. Acupuncture Services Acupuncture services for pain therapy when both of the following are true: • Another method of pain management has failed. • The service is performed in the provider's office by a licensed provider, such as: — A Physician who is certified in the use of acupuncture, or — An acupuncturist licensed by the state or certified by the National Commission of Acupuncturists. Where such Benefits are available, acupuncture is a Covered Health Service for the treatment of: • Nausea caused from Chemotherapy, or • Post-operative nausea, or • Nausea caused from early Pregnancy. For other diagnoses, your provider must contact Care Coordination℠. Benefits are limited to 20 visits per calendar year.	No, except for diagnosis other than those listed at left.	$20 per visit	Yes	No
2. Ambulance Services – Emergency				

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
only Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.	No	Ground Transportation 10%	Yes	Yes
Air ambulance transport is covered only if: • You require transport to a Hospital or from one Hospital to another because the first Hospital does not have the required services and/or facilities to treat the patient, and • Ground ambulance transportation is not medically appropriate because of the distance involved, or because you have an unstable condition requiring medical supervision and rapid transport.	Air Transportation Yes	Air Transportation 10%	Yes	Yes
Notify Care Coordination℠ If you need air Ambulance Services, for example, for transfer from one Hospital to another via air ambulance, please remember you or your provider must notify Care Coordination℠ within two business days, or as soon as possible. Air ambulance services received without notification are not covered unless provided for Emergency. Non-Emergency transportation via ground or air is not covered.				

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
3. Cancer Resource Services	Yes	10%	Yes	Yes

Care Coordination℠ will arrange for access to certain of its Network Providers participating in the Cancer Resource Services Program for the provision of oncology services. You may be referred to Cancer Resource Services by Care Coordination℠, or you may self refer to Cancer Resource Services by calling 866-936-6002. In order to receive the highest level of Benefits, you must contact Cancer Resource Services prior to obtaining Covered Health Services. The oncology services include Covered Health Services and Supplies rendered for the treatment of a condition that has a primary or suspected diagnosis relating to cancer.

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

When these services are not performed in a Cancer Resource Services facility, Benefits will be paid the same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services listed in this section.

Cancer clinical trials and related treatment and services under certain circumstances may be a covered service. Such treatment and services must be recommended and provided by a Physician in a cancer center. The cancer center must be a participating center in the Cancer Resource Services Program at the time the treatment or service is given.

Transportation and Lodging

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?

- A Cancer Resource Services nurse consultant will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the individual receiving cancer-related treatment associated with the Cancer Resource Services program, and a companion are available under this Benefit Program as follows:
- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site where services are given for the purposes of an evaluation, the procedure or other treatment, or necessary post-discharge follow-up.
- Reasonable and necessary 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 patient resides more than 50 miles from the Designated United Resource Networks Facility.
- If the patient is a covered 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 of $10,000 per Covered Person for all transportation, lodging and meal expenses incurred by the patient and companion(s) and reimbursed under this Benefit Program in connection with all transplant procedures or cancer-related services.

4. Congenital Heart Disease Services

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Covered Health Services for Congenital Heart Disease (CHD) services when ordered by a Physician. CHD services may be received at a Congenital Heart Disease Resource Services program. Benefits are available for the CHD services when the services meet the definition of a Covered Health Service, and is not an Experimental or Investigational Service or an Unproven Service. Care Coordination℠ notification is required for all CHD services, including outpatient diagnostic testing, in utero services and evaluation. Congenital heart disease surgical interventions. Interventional cardiac catheterizations. Fetal echocardiograms. Approved fetal interventions. The Copayment and Annual Deductible will apply to Network Benefits when CHD service is received at a Congenital Heart Disease Resource Services program. The services described under **Transportation and Lodging** below are Covered Health Services **ONLY** in connection with CHD services received at a Congenital Heart Disease Resource Services program. CHD services other than those listed above are excluded from coverage, unless determined by Care Coordination to be a proven procedure for the involved diagnoses. Contact Care Coordination℠ at the telephone number on your ID card for information about CHD services.	Yes	10%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Transportation and Lodging				
Care Coordination℠ will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the recipient of CHD services and a companion are available under this Benefit Program as follows: Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of CHD services for the purposes of an evaluation, the 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 CHD recipient resides more than 50 miles from the Congenital Heart Disease Resource Services program. 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 CHD recipient and companion(s) and reimbursed under this Benefit Program in connection with all CHD procedures.				

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Notify Care Coordination℠ You or your provider must notify Care Coordination℠ as soon as CHD is suspected or diagnosed (in utero detection, at birth, or as determined and before the time an evaluation for CHD is performed).				
5. Dental Services – Accident only Dental services when all of the following are true: • Treatment is necessary because of accidental damage due to accident or injury. • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D." • The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was: • A virgin or unrestored tooth, and • 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:	No	$20, or usual copays based on type/place of service	Yes	No

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Started within three months of the accident, and • 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. Covered services in connection with general anesthesia and associated facility charges for dental procedures are payable when provided by or under direction of a Physician or Health Care Provider, when the Covered Person, meets one or more of the following criteria: • The person is under 6 years of age and the treating Provider asserts that general anesthesia is necessary to protect the health of the patient. • The treating Provider affirms that the person is developmentally disabled. • The treating Provider affirms that the person has a non-dental, hazardous physical condition (e.g. heart disease or hemophilia) that makes general anesthesia for that person necessary. Coverage for associated facility charges is subject to all of the same terms and conditions, including the same annual Deductible and Copayments, as for other Covered Services. **Dental anesthesia does not require prior authorization.** Charges for the dental procedure itself, including but not limited to the professional fees of				

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
the dentist, are not covered. **Notify Care Coordination℠** Please remember that you or your provider must notify Care Coordination℠ at the telephone number on your ID card or via www.myuhc.com as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. Notification is not required before the initial Emergency treatment. Upon notification, Care Coordination℠ can verify that the service is a Covered Health Service.				
6. Durable Medical Equipment Durable Medical Equipment that meets each of the following criteria: • Ordered or provided by a Physician for outpatient use. • Used for medical purposes. • Not consumable or disposable. • Not of use to a person in the absence of a disease or disability. If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment. Examples of Durable Medical Equipment include: • Equipment to assist mobility, such as a standard wheelchair. • A standard Hospital-type bed.	Yes	10%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Oxygen concentrator units and the rental of equipment to administer oxygen. • Delivery pumps for tube feedings, including tubing and connectors. • Orthotics from a Network provider, only when approved by Care Coordination℠. Covered services include: — Braces that straighten or change the shape of a body part. — Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. — Shoe orthotics, only when approved by Care Coordination℠ for diabetes. • Mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions. • A device used to monitor glucose levels, if the Covered Person is diagnosed with diabetes Type I or Type II. We provide Benefits for a single unit of Durable Medical Equipment (example: one external insulin pump and pump supplies) and provide repair of that unit for Covered Persons. The following items are covered: • Insulin syringes with needles, • Blood and urine test strips for glucose, • Ketone tablets and test strips,				

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Lancets and lancet devices, • Insulin pump supplies including infusion sets, reservoirs, glass cartridges and insertion sets. • Implantable insulin pumps. • External insulin pump and pump supplies (for patients with Type I diabetes). • External insulin pumps for Type II diabetes. • External insulin pumps that deliver insulin into the intraperitoneal cavity. • Injection aids, including those adaptable to meet the needs of the legally blind. • Shoe orthotics, only when approved by Care Coordination℠ for diabetes. • Medically necessary podiatric appliances for prevention and treatment of foot complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics that have been pre-authorized by Care Coordination℠, custom molded inserts, replacements inserts, preventive devices and shoe modifications. • Glucagon emergency kits.				
• Lenses for aphakic patients (those with no lens in the eye) and soft lenses or sclera shells (white supporting tissue of eyeball). Either one set of prescription glasses or one set of contact				

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
lenses (whichever is appropriate) when necessary to replace enses absent at birth or lost through cataract surgery or other intraocular surgery or ocular injury. Lenses prescribed by a physician as the only treatment available for keratoconus may be covered under your vision plan. Duplicate glasses/lenses are not covered. Replacement is covered only if a physician or optometrist recommends a change in prescription due to a change in medical condition Benefits are provided for the replacement of a type of Durable Medical Equipment once every three calendar years. Care Coordination℠ will decide if the equipment should be purchased or rented. You must purchase or rent the Durable Medical Equipment from the vendor that Care Coordination℠ identifies as appropriate. **Notify Care Coordination℠** Please remember that you or your provider must notify Care Coordination℠ before obtaining orthotics and any single item of Durable Medical Equipment that costs more than $500, or that requires long-term rental. Without notification, you will be responsible for paying all charges and no Benefits will be paid.				
7. Emergency Health Services In order to receive the level of benefits outlined in this section, a condition, Sickness or Injury must be a true Emergency. See definition of Emergency in (Section 10: Glossary of Defined Terms). Otherwise, your service will not be covered. In addition, ancillary services such as lab tests, will not be covered if you receive	Yes, but only for inpatient stay.	$75 per visit, waived if admitted Ancillary Services 10%	Yes Yes	No Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Emergency Health Services for a non-Emergency. Generally speaking, Emergency Health Services are those that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility. You will find more information about Benefits for Emergency Health Services in (Section 3: Obtaining Benefits). **Notify Care Coordination℠** Please remember that if you are admitted to a Non-Network Hospital as a result of an Emergency, you or your provider must notify Care Coordination℠ within two business days, or as soon as reasonably possible.		Physician Services 10%	Yes	Yes
8. Family Planning Family Planning benefits include the following: • Voluntary Sterilization. • IUD. • Diaphragm. • Depo-Provera. Oral contraceptives are covered under the Outpatient Prescription Drug Rider.	No	$20 per visit for office visit only All Other Services 10%	Yes Yes	No Yes
9. Hearing Hearing benefits include the following:	No	Hearing aids 50%, up to $2,000 maximum	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Digital and analog hearing devices. • Benefits for hearing aids are limited to one standard hearing aid per ear every 36 months. • Charges by a licensed or certified audiologist for Physician-prescribed hearing evaluations to determine the location of a disease within the auditory system; for validation or organicity tests to confirm an organic hearing problem.		Cochlear implants and hearing testing 10%	Yes	Yes
• Diagnosis of severe to profound bilateral sensorineural hearing loss and severely difficult speech discrimination. • Post-lingual sensorineural deafness in an adult. • Cochlear Implant when diagnosis of severe to profound bilateral sensorineural hearing loss and severely difficult speech discrimination or post-lingual sensorineural deafness in an adult.		All Other Covered Hearing Benefits $20 per visit	Yes	No

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
10. Home Health Care Services received from a Home Health Agency that are: • Ordered by a Physician; and • 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; and • 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. Care Coordination℠ 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.	Yes	Private Duty Nursing 10% All Other Home Health Care 10%	Yes Yes	Yes No

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Notify Care Coordination℠ Please remember that you or your provider must notify Care Coordination℠ five business days before you receive home health care or private duty nursing services.				
11. Hospice Care Hospice care that is recommended by a Physician and received from a licensed hospice agency. 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 limited to $7,400 during the entire period of time you are covered under the Benefit Program. Benefits for bereavement counseling are limited to three visits during the entire period of time you are covered under the Benefit Program. **Notify Care Coordination℠** Please remember that you or your provider must notify Care Coordination℠ five business days before you receive services.	Yes	Bereavement Counseling 10% All Other Hospice Care 10%	Yes Yes	No No
12. Hospital and Birthing Centers – 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 beds). Private rooms are covered up to the highest Semi-private Room rate for that Hospital.	Yes for Hospital and Yes, for Birthing Centers if Inpatient Stay exceeds time frames listed under Maternity Services.	10%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Intensive Care. • Laboratory, X-ray and other testing required during your inpatient stay. Inpatient Stay in a birthing center. 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). Private rooms are covered up to the highest Semi-private Room rate for that facility. • Laboratory expenses. **Notify Care Coordination℠** Please remember that you or your provider must notify Care Coordination℠ as follows: • For elective admissions: five business days before admission. • For non-elective admissions: within one business day or the same day of admission. • For Emergency admissions: within two business days, or as soon as is reasonably possible. See Professional Fees for Surgical and Medical Services for other inpatient Surgery Fees and Outpatient Surgery, Diagnostic and Therapeutic Services for other laboratory expenses.				

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
13. Infertility Services Covered Health Services for infertility services and associated expenses for the diagnosis and treatment of the underlying medical cause of infertility when provided by or under the direction of a Physician.	No	$20 per visit	Yes	No
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.	No	Allergy Injections No Copayment All Other Injections 10%	No Yes	No Yes
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. Services of a licensed, certified Network midwife are covered the same way as any other Network Physician Services. Anesthesia for maternity is covered in full. 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 must notify Care Coordination℠ during the expected mother's first trimester, but no later than one	Yes, if Inpatient Stay exceeds time frames.	Same as *Physician's Office Services, Professional Fees for Surgical and Medical Services – Inpatient Surgery, Hospital and Birthing Centers – Inpatient Stay,* and *Outpatient Diagnostic and Therapeutic Services,* respectively No Copayment applies to Physician office visits for prenatal care after the first visit		

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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. • 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. **Notify Care Coordination℠** Please remember that you or your provider must notify Care Coordination℠ as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described above in this section.				
16. Nutrition **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: • Diabetes mellitus. • Coronary artery disease.	No	$20 per visit	Yes	No

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• 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. **Enteral Nutrition** Enteral feeding is covered when it is the sole source of nutrition or when a certain nutritional formula treats a specific inborn error of metabolism. Non-prescription enteral products are covered.				
17. Orthognathic Surgery Orthognathic Surgery, which is surgery to correct the deformity of the jaw, includes only the following oral surgical procedures: • Medically necessary orthognathic surgery if Care Coordination℠ is notified as outlined below. • External or intraoral cutting and draining of cellulitis, which are cells affected by a bacterial infection. This does not include treatment of dental-related abscesses. • Incision of accessory sinuses, salivary glands or ducts.	Yes	10%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Lingual frenectomy. • Removal or biopsy of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of mouth when pathological examination is required. **Notify Care Coordination℠** Please remember that you or your provider must notify Care Coordination℠ five business days before you receive services.				
18. Ostomy Supplies Benefits for Ostomy Supplies include only the following: • Pouches, face plates and belt • Irrigation sleeves, bags and catheters. • Skin barriers.	No	10%	Yes	Yes
19. Outpatient Surgery, Diagnostic and Therapeutic Services Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including: • Pre-admission testing. • Surgery and related services. • Lab, radiology and X-ray. • Mammography testing. • Other diagnostic tests and therapeutic treatments including	No	10%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
cancer chemotherapy, dialysis and intravenous infusion therapy. Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient surgery, diagnostic and therapeutic services are described under *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.				
20. Physician's Office Services Covered Health Services received in a Network Physician's office including: • Outpatient surgery. • Treatment of a Sickness or Injury. • Preventive medical care. • Well-baby and well-child care, including well-baby circumcisions. • Routine well-woman examinations, including Pap smears, pelvic examinations, mammograms, immunizations (except for travel-related immunizations), lab tests and X-rays for women ages 19 and older. • Routine well-man examinations, including PSA testing, immunizations (except for travel-related immunizations), lab tests and X-rays for men ages 19 and older.	No	Well-baby and well-child care through age 2 No Copayment Preventive vision and hearing screening through age 2 No Copayment Allergy injections No Copayment Immunizations No Copayment	No No No No	No No No No

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Routine physical examinations, including vision screenings through age 18 and hearing screenings through age 18. Vision screenings do not include refractive examinations to detect vision impairment. • Second/third surgical opinions. • Allergy Care.		All Other Physician's Office Services $20 per visit	Yes	No
21. Professional Fees for Surgical and Medical Services – Inpatient Surgery Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above. Covered Expenses for multiple surgical procedures are limited as follows: • Covered Expenses for a secondary procedure are limited to 50% of the Covered Expenses that would otherwise be considered for the secondary procedure had it been performed during a separate operative session. Covered Expenses for any subsequent procedures are limited to 50% of the Covered Expenses that would otherwise be considered for the subsequent procedure had it been performed during a	No, except for obesity surgery	Physician's visit during inpatient stay No Copayment All Other Surgical Services 10%	No Yes	No Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
separate operative session. **Notify Care Coordination℠** Please remember that you or your provider must notify Care Coordination℠ five business days before you receive services for obesity surgery.				
22. Prosthetic Devices Prosthetic devices that replace a limb or body part including: • Artificial limbs. • Artificial eyes. • Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device. The prosthetic device must be ordered or provided by, or under the direction of a Physician. 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 three calendar years. **Notify Care Coordination℠** Please remember that you or your provider must notify Care Coordination℠ before obtaining any single item that costs more	Yes, for items costing $500 or more, or requiring long-term rental	10%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
than $500, or that requires long-term rental.				
23. 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. 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 or socially avoidant behavior 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 a bodily function such as breathing. This Benefit Program does not provide Benefits for Cosmetic Procedures. Some services are considered reconstructive in some circumstances and cosmetic 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. In other situations, the purpose would be to improve appearance only, and a function, such as vision, would not be affected. A good example is upper eyelid surgery. At times, this procedure will improve vision, while on other occasions	Yes	Same as *Physician's Office Services, Professional Fees, Hospital – Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.*		

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
improvement in appearance is the primary or only 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 1998, 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 Care Coordination℠ at the telephone number on your ID card or via www.myuhc.com for more information about Benefits for mastectomy-related services. **Notify Care Coordination℠** Please remember that you or your provider must notify Care Coordination℠ five business days before you receive services. Examples of procedures that require notification include blepharoplasty, breast reduction, breast reconstruction, ligation, vein stripping and sclerotherapy. Care Coordination℠ can verify that the service is a reconstructive procedure rather than a Cosmetic Procedure. Cosmetic Procedures are always excluded from coverage.				
24. Rehabilitation Services – Outpatient Therapy Short-term outpatient rehabilitation services for: • Physical therapy. • Occupational therapy.	No, except for cardiac rehabilitation therapy – see below.	$20 per visit	Yes	No

- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.

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

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

Please note that we will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly or is required following the placement of a cochlear implant.

Speech Therapy for Children Under Age Three

Benefits are provided for services provided by a licensed speech therapist for treatment given to a child under age three whose speech is impaired due to one of the following conditions:

- Infantile autism.
- Developmental delay or cerebral palsy.
- Hearing impairment.
- Major congenital anomalies that affect speech such as, but not limited to, cleft lip and cleft palate.

Please note that the Benefit Program excludes any type of therapy,

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
service or supply 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. **Visit Maximums** Benefits are limited as follows: *(please see below for additional benefits)* • 20 visits of physical therapy per calendar year. • 20 visits of occupational therapy per calendar year. • 20 visits of speech therapy per calendar year. • Visit limitation on cardiac and pulmonary rehabilitation therapy is based on medical necessity. Additional visits for rehabilitation services may be considered covered services if Care Coordination determines the visits are necessary and continued treatment is prescribed by a physician. Services are expected to result in significant physical improvement. Covered Persons who have unusual circumstances that may require services beyond 36 visits of cardiac rehabilitation therapy, or request repeat entry into a cardiac rehabilitation program without a qualifying event, must have their Primary Physician call Care Coordination.				
25. Rehabilitation Services – Inpatient/Skilled Nursing Facility Services for an Inpatient Stay in a Skilled Nursing Facility or	Yes	10%	Yes	No

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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). Benefits are limited to 100 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 Sickness that requires an intensity of care or a combination of skilled nursing, rehabilitation and facility services that 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. 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				

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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 Care Coordination℠** Please remember that you or your provider must notify Care Coordination℠ as follows: • For elective admissions: five business days before admission. • For non-elective admission: within one business day. • For Emergency admissions: within two business days, or as soon as is reasonably possible.				
26. Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy Benefits for Spinal Treatment include chiropractic and osteopathic manipulative therapy. Benefits for Spinal Treatment are available when Spinal Treatment is provided by a Network Spinal Treatment provider in the provider's office. Benefits include diagnosis and related services and are limited to one visit and treatment per day. Please note that the Benefit Program 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	No	$20 per visit	Yes	No

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
reoccurring. Benefits for Spinal Treatment, Chiropractic, and Osteopathic Manipulative Therapy are limited to 20 visits per calendar year.				

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
27. Temporomandibular Joint Disorder Services for the treatment of TMJ include only the following: • Arthrocentesis proven for the treatment of: — Documented, symptomatic degenerative joint disease osteoarthritis, or — Documented, intracapsular soft tissue abnormalities, such as disc displacement or adhesions. • Arthroplasty proven for the treatment of: — Documented, symptomatic osteophytes affecting the temporomandibular joint, or — Documented, symptomatic intracapsular soft tissue abnormality (such as disc displacement or adhesions). **Notify Care Coordination℠** Please remember that you or your provider must notify Care Coordination℠ within two business days, or as soon as possible for inpatient services. Without notification, you will be responsible for paying all charges and no Benefits will be paid.	Yes for inpatient services	10%, or usual copays based on type/place of service	Yes	Yes
29. Transplantation Services Covered Health Services for the following organ and tissue transplants when ordered by a Network Physician. Transplantation services must be received at a Designated United Resource Network Facility. Benefits are available for the transplants listed below when	Yes	10%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
the transplant meets the definition of a Covered Health Services, and is not an Experimental or Investigational Service or an Unproven Service. Care Coordination℠ notification is required for all transplant services. • 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. If a separate charge is made for bone marrow/stem cell search, a Maximum Benefit of $25,000 is payable for all charges made in connection with the search. • Heart transplants. • Heart/lung transplants. • Lung transplants. • Kidney transplants. • Kidney/pancreas transplants. • Liver transplants. • Liver/small bowel transplants. • Pancreas transplants. • Small bowel transplants. Benefits are also available for cornea transplants that are provided by a Network Physician at a Network Hospital. We do not require that				

cornea transplants be performed at a Designated United Resource Network Facility.

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

Under the Benefit Program there are specific guidelines regarding Benefits for transplant services. Contact Care Coordination℠ at the telephone number on your ID card or via www.myuhc.com for information about these guidelines.

Transportation and Lodging

Care Coordination℠ will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Benefit Program 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

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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 Benefit Program in connection with all transplant procedures.				
30. 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.	No	$20 per visit Ancillary Services 10%	Yes Yes	No Yes

Section 2: What's Not Covered--Exclusions

This section contains information about:

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

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 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.

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

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

A. Alternative Treatments

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

B. Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber services.
4. Guest services.
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.

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

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.

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

4. Over the counter drugs and treatments.
5. Norplant.

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 shoe orthotics for diabetes only, when covered under *Durable Medical Equipment*.

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

G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. 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

Services for the treatment of Mental Illness or mental health conditions and substance abuse services and chemical dependency services.

I. Nutrition

1. Megavitamin and nutrition-based therapy.
2. Except as described in (Section 1: What's Covered – Benefits) under *Nutrition,* nutritional counseling for either individuals or groups, including obesity control programs, weight loss programs, health clubs and spa programs and conditions that have been shown to be nutritionally related, including but not limited to chronic fatigue syndrome and hyperactivity.
3. Except as described in (Section 1: What's Covered – Benefits) under *Nutrition*, enteral feedings and other nutritional and electrolyte supplements, 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 they are the sole source of nutrition or except when a certain nutritional formula treats a specific inborn error of metabolism.

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

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 for medical reasons.
5. Wigs regardless of the reason for the hair loss.

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

K. Providers

1. Services performed by a provider who is a family member by birth, marriage, or law including spouse, domestic partner, 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.
4. Services provided by a provider who is not a part of the Claims Administrator's contracted Network, except in the event of an Emergency.

L. Reproduction

1. Surrogate parenting.
2. The reversal of voluntary sterilization.
3. Fees or direct payment to a donor for sperm, ova or embryonic donations.
4. Monthly fees for maintenance and/or storage of frozen sperm, ova or embryos.
5. Health services and associated expenses for infertility treatment. This Benefit Program does not cover assisted reproductive technology (artificial insemination, invitro fertilization, GIFT and ZIFT).
6. Oral contraceptive supplies and services. These are included, however, as part of the Prescription Drug Benefit.

M. Services Provided Under Another Plan Program

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

N. Transplants

1. Health services for organ and tissue transplants, except those described in (Section 1: What's Covered--Benefits).

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

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

2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Benefit Program.)
3. Health services for transplants involving mechanical or animal organs.
4. Transplant services that are not performed at a Designated United Resource Network Facility.
5. Any solid organ transplant that is performed as a treatment for cancer.
6. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Health Services* in (Section 1: What's Covered-Benefits).

O. Travel

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

P. Vision and Hearing

1. Purchase cost of eye glasses or contact lenses, except as may be specifically provided for in (Section 1: What's Covered--Benefits).
2. Fitting charge for eye glasses or contact lenses.
3. Eye exercise therapy.
4. Surgery that is intended to allow you to see better without glasses, or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

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5. Vision and hearing screening after age 18.
6. Routine exams for vision and hearing.

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 Benefit Program 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 the purpose 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 Benefit Program ends, including health services for medical conditions arising before the date your coverage under the Benefit Program 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 Benefit Program.
6. For Emergencies, 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.

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7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered to be dental in nature, including oral appliances, except in the event of an accident.
9. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly, except as noted under *Rehabilitation Services – Outpatient Therapy*.
10. Growth hormone therapy.
11. Sex transformation operations and transgender reassignment benefits
12. Custodial Care.
13. Domiciliary care.
14. Private duty nursing, except as outlined under *Home Health Care* in (Section 1: What's Covered--Benefits).
15. Rest cures.
16. Psychosurgery.
17. Treatment of benign gynecomastia, a condition of abnormal breast enlargement in males.
18. Medical and surgical treatment of excessive sweating, a condition known as hyperhidrosis.
19. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

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20. Appliances to treat snoring.
21. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
22. 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.
23. Any charge for services, supplies or equipment advertised by the provider as free.
24. Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency.
25. Any charges prohibited by federal anti-kickback or self-referral statutes.
26. Any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services.
27. 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 that 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.
28. Speech therapy to treat learning disabilities, developmental delays, stuttering, stammering, or other articulation disorders.
29. Orthoptic therapy.
30. Vocational rehabilitation training.
31. Liposuction.
32. Chelation therapy, except to treat heavy metal poisoning.
33. Personal trainers.
34. Naturalist.
35. Holistic or homeopathic care.
36. Virtual colonoscopy.

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Section 3: Obtaining Benefits

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

Benefits

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

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

Benefits are not payable for Covered Health Services that are provided by Non-Network providers.

Selecting a Primary Physician

You must select a Primary Physician. Your Primary Physician will coordinate all Covered Health Services and ensure continuity of care.

If you are the custodial parent of an Enrolled Dependent child, you must select a Primary Physician for that child.

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

You may change your Primary Physician by contacting us at the telephone number shown on your ID card or via www.myuhc.com.

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 ensure 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 myuhc.com. However, before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status or request a provider directory 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.

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 participate in some networks and/or plans but not others. Refer to your provider directory or contact the Claims Administrator for assistance.

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Care Coordination[SM]

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

If you receive certain Covered Health Services from a Network provider, you or the provider must notify Care Coordination[SM]. The Covered Health Services for which notification is required is shown in (Section 1: What's Covered--Benefits). When you or your provider notify Care Coordination[SM], you will be provided with the Care Coordination[SM] services described above.

Designated United Resource Network Facilities and Other Providers

If you have a medical condition that Care Coordination[SM] believes needs special services, such as the transplantation of an organ, Care Coordination[SM] may direct you to a Designated United Resource Network Facility or other provider chosen by them. If you require certain complex Covered Health Services for which expertise is limited, Care Coordination[SM] 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 Care Coordination[SM].

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Benefits for Health Services from Non-Network Providers

If specific Covered Health Services are not available from a Network provider, you may be eligible for Benefits when Covered Health Services are received from Non-Network providers. In this situation, your Primary Physician will notify Care Coordination[SM], and they will work with you and your Primary Physician to coordinate care through a Non-Network provider.

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

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.

Whenever possible, you should contact your Primary Physician before receiving Emergency Health Services, and then seek care from the Network provider he or she designates.

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

- If you are confined in a Non-Network Hospital after you receive Emergency Health Services, Care Coordination[SM] must be notified within two business days or on the same day of admission if reasonably possible. Care Coordination[SM] may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the Non-Network Hospital after the date Care Coordination[SM] decides a transfer is medically appropriate, Benefits will not be available.

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- If you are admitted as an inpatient to a Network Hospital within 24 hours of receiving treatment for the same condition as an Emergency Health Service, you will not have to pay the Copayment for Emergency Health Services. The Copayment for an Inpatient Stay in a Network Hospital will apply instead.

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

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Section 4: When Coverage Begins

This section includes information about if you are hospitalized when this coverage begins or if you are Eligible for Medicare.

Please refer to LANS Welfare Benefit Plan for Employee Summary Plan Description for Eligibility, Enrollment, Termination, and Plan Administration information.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Benefit Program.

You should notify the Claims Administrator within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Benefits are available only if you receive Covered Health Services at a Network facility under the direction of your Primary Physician.

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Section 5: How to File a Claim

This section provides you with information about:

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

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact the Claims Administrator. However, you are responsible for meeting the Annual Deductible and for paying Copayments 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 as a result of an Emergency or if we refer you to a Non-Network provider, you are responsible for requesting payment from

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

us through the Claims Administrator. You must file the claim in a format that contains all of the information required, as described below.

You must submit a request for payment of Benefits within one year after the date of service. If a Non-Network provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. If you don't provide this information to us within **one year** of the date of service, Benefits for that health service will be denied or reduced, at 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 an Employee 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 Employee. We will not reimburse third parties who have purchased or been assigned benefits by Physicians or other providers.

Pharmacy Benefit Claims

If you are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy and you believe that the Benefit Program should have paid for it, you may submit a claim for reimbursement as set forth in the procedures for filing a post-service group health plan claim (described in this section). If you pay a copayment and you believe that the amount of the copayment was incorrect, you also may submit a claim for reimbursement as set forth in the procedures for filing a post-service group health plan claim.

If a retail or mail order pharmacy fails to fill a prescription that you have presented, you may contact us by submitting a claim for

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coverage as set forth in the procedures for filing a pre-service health plan claim (described in this section).

Required Information

When you (or your Network provider) request payment of Benefits from us, you must provide us with all of the following information:

A. Employee's name and address.
B. The patient's name, age and relationship to the Employee.
C. The member number stated on your ID card or via www.myuhc.com.
D. An itemized bill from your provider that includes the following:
   - Patient Diagnosis
   - Date(s) of service
   - Procedure Code(s) and descriptions of service(s) rendered
   - Charge for each service rendered
   - Provider of service Name, Address and Tax Identification Number
E. The date the Injury or Sickness began.
F. A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage, you must include the name of the other carrier(s).

Payment of Benefits

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

A. The provider notifies the Claims Administrator that your signature is on file, assigning benefits directly to that provider.

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B. You make a written request for the Non-Network provider to be paid directly at the time you submit your claim.

Benefit Determinations

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 or your Network provider filed a pre-service claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within five days after the pre-service claim was received. If additional information is needed to process the pre-service claim, the Claims Administrator will notify you of the information needed within 15 days after the claim was received, 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 Benefit Program on which the denial is based, and provide the claim appeal procedures.

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

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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.

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

Urgent Claims that Require Immediate Action

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

If you filed an urgent claim improperly, the Claims Administrator will notify you or your Network provider 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 Benefit Program on which the denial was based, and provide the claim appeal procedures.

Concurrent Care Claims

If an ongoing 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 ongoing 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

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circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

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Section 6: Questions and Appeals

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

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

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

What to Do First

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

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

The Customer Service telephone number is shown on your ID card or via www.myuhc.com. 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 Covered Person's name and the identification number from the
  ID card or via www.myuhc.com.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

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

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation

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with a health care professional with appropriate expertise in the field who was not involved in the prior determination. 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. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeals Determinations

Pre-Service and Post-Service Claim Appeals

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

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

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

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

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

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

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Benefit Program 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.

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

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 Experimental, Investigational or Unproven Services.

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

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

Your Rights and Privileges under ERISA

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). For more information please refer to the **LANS Health & Welfare Benefit Plan for Employees Summary Plan Description** or the **LANS Health & Welfare Benefit Plan for Retirees Summary Plan Description.**

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Section 7: Coordination of Benefits

This section provides you with information about:

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

Benefits When You Have Coverage Under More Than One Plan

This section describes how Benefits under the Plan will be coordinated with those of any other plan that provides Benefits to you.

The language in this section, except when coordinating with Medicare, 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 Covered Person has health care coverage under more than one benefit plan.

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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 (does not apply when coordinating with Medicare).

Definitions

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

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

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

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

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

3. "Allowable Expense" means a health care service or expense, including deductibles and Copayments, that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides Benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. 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:

   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.

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

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

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

   e. The amount a benefit is reduced by the Primary Coverage Plan because a Covered Person does not comply with the Coverage Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

4. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect. This provision does not apply when coordinating with Medicare.

5. "Closed Panel Plan" is a Coverage Plan that provides health Benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes Benefits for services provided by other providers, except in cases of Emergency or referral by a panel member.

6. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with

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whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules

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

A. The Primary Coverage Plan pays or provides its Benefits as if the Secondary Coverage Plan or Coverage Plans did not exist.

B. A Coverage Plan that does not contain a coordination of Benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of Benefits may provide that the supplementary coverage shall be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan Hospital and surgical Benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide 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 an employee, member, subscriber or retiree is primary and the Coverage Plan that covers the person as a Dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage Plan covering the person as a Dependent; and primary to the Coverage Plan covering the person as other than a Dependent (e.g. a retired employee); then the order of Benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Coverage Plan is primary.

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:

      1) The parents are married;

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

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

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

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

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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 employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a Dependent of a person covered as a retiree and an employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of Benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a Dependent of an actively working spouse will be determined under the rule labeled D(1).
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 an employee, member, subscriber or retiree (or as that person's Dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of Benefits, this rule is ignored.
6. Longer or shorter length of coverage. The Coverage Plan that covered the person as an employee, member, subscriber or retiree longer is primary.

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7. If a husband or wife is covered under this Coverage Plan as an Employee and as an Enrolled Dependent, the Dependent Benefits will be coordinated as if they were provided under another Coverage Plan, this means the Employee's 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.

Effect on the Benefits of this Plan

A1. Coordinating with Non-Medicare Plan: 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

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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.

A2. Coordinating with Medicare: When this Coverage Plan is secondary, it may reduce its Benefits by the total amount of Benefits paid or provided by all Coverage Plans that are primary to this Coverage Plan. As each claim is submitted, this Coverage Plan will:

1. Determine its obligation to pay or provide Benefits under its plan;
2. Determine the difference between the benefit payments that this Coverage Plan would have paid had it been the Primary Coverage Plan and the benefit payments paid or provided by all Coverage Plans Primary to this Coverage Plan.

If there is a difference, this Coverage Plan will pay that amount. Benefits paid or provided by this Coverage Plan plus those of Coverage Plans that are primary to this Coverage Plan may be less than 100% of total Allowable Expenses

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

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

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

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- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare Benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a Plan with a Medicare Medical Savings Account. Medicare Benefits are determined as if the person were covered under Medicare Parts A and B.

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

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paid under this Coverage Plan. We will not have to pay that amount again. The term "payment made" includes providing Benefits in the form of services, in which case "payment made" means reasonable cash value of the Benefits provided in the form of services.

Right of Recovery

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the Benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

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Section 8: When Coverage Ends

Please refer to the LANS Welfare Benefit Plan for Employee Summary Plan Description for Eligibility, Enrollment, Termination, and Plan Administration information.

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).
- Conversion

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

General Information about When Coverage Ends

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

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

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

An Enrolled Dependent's coverage ends on the date the Employee's coverage ends or sooner if the Employee chooses to end the Dependent's coverage or as otherwise set forth in this Benefit Program Summary.

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

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	**Please refer to the LANS Welfare Benefit Plan for Employees Summary Plan Description for Eligibility, Enrollment, Termination, and Plan Administration information.**
You Are No Longer Eligible	
The Claims Administrator Receives Notice to End Coverage	
Employee Retires or Is Pensioned	

Other Events Ending Your Coverage

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

Ending Event	What Happens
Fraud, Misrepresentation or False Information	**Please refer to the LANS Welfare Benefit Plan for Employees Summary Plan Description for Eligibility, Enrollment, Termination, and Plan Administration information.**
Material Violation	
Improper Use of ID Card	
Failure to Pay	
Threatening Behavior	

Coverage for a Handicapped Child

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

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

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

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

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

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

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

Extended Coverage for Total Disability

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

- The Total Disability ends.
- Twelve months from the date coverage would have ended,
- The maximum benefits available to the Covered Person under this plan are paid; or
- The date the Covered Person becomes covered under another group health plan that provides coverage without limitation for the condition causing the Total Disability.

Continuation of Coverage and Conversion

Please refer to the LANS Welfare Benefit Plan for Employees Summary Plan Description for Eligibility, Enrollment, Termination, and Plan Administration information.

Continuation of Group Health Plan Coverage

Health care coverage for yourself, spouse or Dependents continues if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependent may have to pay for such coverage. Review this Benefit Program Summary 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 occurs under your group health Plan, if you

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have creditable coverage from another group health Plan. You should be provided a certificate of creditable coverage in writing, free of charge automatically, from the Plan 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 calling the number on the back of your ID card. 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 succeeding coverage.

Conversion

If your coverage terminates for one of the reasons described below, you may apply for conversion coverage, without furnishing evidence of insurability, if:

- You are no longer eligible.
- Your continuation coverage ends.

This right to conversion coverage is contingent upon the exhaustion of COBRA continuation coverage. In addition, you may not be eligible for conversion coverage if you are:

- Age 65 or older.
- Covered under or eligible for coverage under Medicare (title XVIII as amended).

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- Covered under or eligible for any group, individual, prepayment, government, or other plan or program which would result in overinsurance if conversion coverage was issued.

You must submit your first application and payment to the Claims Administrator or its designated insurance company within 31 days after coverage ends under this Plan. The Claims Administrator or its designated insurance company will issue conversion coverage according to the terms and conditions in effect at the time you apply. Conversion coverage may be substantially different from coverage provided under this Plan. Even though you may be eligible for conversion coverage, a conversion policy may not be available in certain states. When a conversion policy is not available, the conversion coverage may be provided by a state sponsored risk pool.

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Section 9: General Legal Provisions

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

Please refer to your LANS SPD for more information.

Plan Document

This Benefit Program Summary presents an overview of your Benefits. In the event of any discrepancy between this Benefit Program Summary 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 facilities. The credentialing process confirms public information about the

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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 Plan Administrator for any purpose with respect to the administration or provision of Benefits under this Plan.

The Plan 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.

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

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Incentives to Providers

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

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost effectiveness.

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 or via www.myuhc.com. They can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

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

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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 Benefit Program Summary and any Riders and Amendments.
- Make factual determinations related to the Plan and its Benefits.

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

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

Administrative Services

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

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Clerical Error

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

Information and Records

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

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

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

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

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

Examination of Covered Persons

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.

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. If you receive a Benefit payment from the Plan for an Injury caused by a third party, and you later receive any payment for that same condition or Injury from another person, organization or insurance company, we have the right to recover any payments made by the

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Plan to you. This process of recovering earlier payments is called subrogation. In case of subrogation, you may be asked to sign and deliver information or documents necessary for us to protect our right to recover Benefit payments made. You agree to provide us all assistance necessary as a condition of participation in the Plan, including cooperation and information submitted to or supplied by a workers' compensation, liability insurance carrier, and any medical Benefits, no-fault insurance, or school insurance coverage that are paid or payable.

We shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type, for the reasonable value of services and Benefits we provided to you from any or all of the following:

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity obligated to provide Benefits or payments to you, including Benefits or payments for underinsured or uninsured motorist protection (these third parties and persons or entities are collectively referred to as "Third Parties").

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You agree as follows:

- To assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided, plus reasonable costs of collection.
- To cooperate with us in protecting our legal rights to subrogation and reimbursement.
- That our rights will be considered as the first priority claim against Third Parties, to be paid before any other of your claims are paid.
- That you will do nothing to prejudice our rights under this provision, either before or after the need for services or Benefits under the Plan.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including filing suit in your name.
- That regardless of whether or not you have been fully compensated, we may collect from the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, the reasonable value of services provided under the Plan.
- To hold in trust for our benefit under these subrogation provisions any proceeds of settlement or judgment.
- That we shall be entitled to recover reasonable attorney fees from you incurred in collecting proceeds held by you.
- That you will not accept any settlement that does not fully compensate or reimburse us without our written approval.
- To execute and deliver such documents (including a written confirmation of assignment, and consent to release medical

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records), and provide such help (including responding to requests for information about any accident or injuries and making court appearances) as we may reasonably request from you.

- We will not pay fees, costs or expenses you incur with any claim or lawsuit, without our prior written consent.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if either of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Plan.

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

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

Limitation of Action

If you want to bring an arbitration action against us or the Claims Administrator you must do so within one year 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 arbitration 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 one year of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against us or the Claims Administrator.

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Section 10: Glossary of Defined Terms

This section:

- Defines the terms used throughout this Benefit Program Summary.
- Is not intended to describe Benefits.

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

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

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.

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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 Benefit Program Summary and any applicable Riders and Amendments.

Benefit Program – Select EPO plan. References to "we," "us," and "our" throughout the Benefit Program Summary refer to the Benefit Program.

Cancer Resource Services Program – the Claims Administrator's program made available by the Employer to Employees. The Cancer Resource Services Program provides information to Employees or their Covered Dependents with cancer and offers access to additional cancer centers for the treatment of cancer.

Care Coordination℠ – 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.

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

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

Congenital Heart Disease Program – the Claims Administrator's program made available by the Employer to Employees. The Congenital Heart Disease Program provides information to Employees or their Covered Dependents with congenital heart disease and offers access to additional centers for the treatment of congenital heart disease.

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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 Care Coordination℠ 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:

- When the Plan is in effect;
- Prior to the effective date of any of the individual termination conditions set forth in this Benefit Program Summary; 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 Employee, Retiree or Survivor or an Enrolled Dependent, but this term applies only while the person is enrolled under the Plan. References to "you" and "your" throughout this Benefit Program Summary are references to a Covered Person.

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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 that do not seek to cure, or that are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Designated 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.

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.

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- Is appropriate for use in the home.

Eligible Expenses – the amount we will pay for Covered Health Services, incurred while the Plan is in effect, are determined as stated below. Eligible Expenses are based on either of the following:

- When Covered Health Services are received from Network providers, Eligible Expenses are the contracted fee(s) with that provider.
- When Covered Health Services are received from Non-Network providers as a result of an Emergency or as otherwise arranged through the Claims Administrator, Eligible Expenses are the fee(s) that are negotiated with the Non-Network provider.

Emergency – a serious medical condition or symptom resulting from Injury, Sickness or mental illness that 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.

Employee – an Eligible Person who is properly enrolled under the Benefit Program. The Employee is the person (who is not a Dependent) on whose behalf the Benefit Program is established.

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

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

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

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

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

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

- Is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and

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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.

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.

LANS – Los Alamos National Security, LLC

LANS SPD – LANS Welfare Benefit Plan for Employees Summary Plan Description or the LANS Welfare Benefit Plan for Retirees Summary Plan Description, as applicable.

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 United HealthCare Plan of the Plan Sponsor. When the Maximum Plan Benefit applies, it is described in (Section 1: What's Covered--Benefits).

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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.

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.

Out-of-Pocket Maximum – the maximum amount of Annual Deductible and Copayments you pay every calendar year. Once you reach the Out-of-Pocket Maximum, 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.
- Copayments for Covered Health Services available by an optional Rider. (For example: Outpatient Prescription Drug Rider.)

Even when the Out-of-Pocket Maximum has been reached, the following will not be paid at 100%:

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- Any charges for non-Covered Health Services.
- Covered Health Services available by an optional Rider.
- Covered Health Services in (Section 1: What's Covered-Benefits) that are subject to Copayments that do not apply to the Out-of-Pocket Maximum.

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

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, Christian Scientist 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.

Plan – LANS Welfare Benefit Plan for Employees or the LANS Welfare Benefit Plan for Retirees, as applicable.

Plan Administrator – Benefits and Investment Committee

Plan Sponsor – LANS

Pregnancy – includes all of the following:

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

Primary Physician – a Network Physician that you select to be responsible for providing or coordinating all Covered Health Services. A Primary Physician has entered into an agreement with the Claims Administrator to provide primary care health services to Covered Persons. The majority of his or her practice generally includes pediatrics, internal medicine, obstetrics/gynecology, or family or general practice.

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

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

Sickness – physical illness, disease or Pregnancy. The term Sickness as used in this Benefit Program Summary does not include mental illness or substance abuse, regardless of the cause or origin of the mental illness or substance abuse.

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

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

Total Disability or Totally Disabled – an Employee'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 (Retiree's/Survivor's), inability to perform the normal activities of a person of like age and sex.

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

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

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

If you have a life-threatening Sickness or condition (one that is likely to cause death within 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 Injury, Sickness, or the onset of acute or severe symptoms.

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Riders, Amendments, Notices

Outpatient Prescription Drug Rider

Select EPO Plan

for

LANS

Outpatient Prescription Drug Rider

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Outpatient Prescription Drug Rider

This Rider to the Benefit Program Summary provides Benefits for outpatient Prescription Drug Products.

Benefits are provided for outpatient Prescription Drug Products at a Network Pharmacy.

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

NOTE: The Coordination of Benefits provision (Section 7: Coordination of Benefits) in the Benefit Program Summary does not apply to Prescription Drug Products covered through this Rider. Prescription Drug Product Benefits will not be coordinated with those of any other health coverage plan.

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Introduction

Coverage Policies and Guidelines

The Claims Administrator's Pharmacy and Therapeutics Committee is the national committee that reviews all drugs that are newly approved by the FDA. The Pharmacy and Therapeutics Committee evaluates the use of the newly approved prescription drug. The Pharmacy and Therapeutics Committee objectively evaluates drugs for therapeutic treatment and safety. The evaluation includes, but is not limited to: safety and efficacy; supply limits; notification requirements. The Pharmacy and Therapeutics Committee makes recommendations to the Claims Administrator's Preferred Drug List Management Committee for final approval. This two-step process is designed to establish coverage policies and guidelines that promote quality and cost-effective drug therapy.

Even after a drug is included on the Preferred Drug List, this evaluation continues at least annually or as new information becomes available.

Identification Card (ID Card) – Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

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If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the Benefit Program Summary (Section 5: How to File a Claim). When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment, Ancillary Charge and any deductible that applies.

Limitation on Selection of Pharmacies

If the Claims Administrator determines that you are using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, the Claims Administrator may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, the Claims Administrator will select a single Network Pharmacy for you.

Rebates and Other Payments

The Claims Administrator may receive rebates for certain Brand-name drugs included on the Preferred Drug List. These rebates are not considered in calculating any percentage Copayments. We or the Claims Administrator are not required to pass on to you, and do not pass on to you, amounts payable to us or the Claims Administrator under rebate programs or other such discounts.

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Coupons and Incentives

At various times the Claims Administrator may offer coupons or other incentives for certain drugs on the Preferred Drug List. Only your doctor can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

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Section 1: What's Covered--Prescription Drug Benefits

We provide Benefits under the Plan for outpatient Prescription Drug Products:

- Designated as covered at the time the Prescription Order or Refill is dispensed when obtained from a Network Pharmacy.
- Refer to exclusions in your Benefit Program Summary (Section 2: What's Not Covered--Exclusions) and as listed in Section 1 of this Rider.

Benefits for Outpatient Prescription Drug Products

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

Injectable and specialty medications may be covered under the medical Plan that are not covered under the pharmacy Plan. If an injectable or specialty medication is determined not covered under the pharmacy Plan, please contact Pharmacare at 877-287-1234, for more details on medications that may be covered under the medical Plan.

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When a Brand Name Drug Becomes Available as a Generic

The terms "generic" and "brand-name" are used in the health care industry in many different ways. To be sure that you know whether a drug is classified as Brand-name or Generic by use, please review the definitions contained in *Section 2: Glossary of Defined Terms* at the end of this Rider. You should also check the current classification on the Preferred Drug List through the Internet at www.myuhc.com or www.365wellst.com or by calling the telephone number on your ID card.

Supply Limits

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

Note: Some products are subject to additional supply limits based on criteria that the Claims Administrator has developed. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

You may obtain a current list of Prescription Drug Products that have been assigned maximum quantity levels for dispensing through the Internet at www.myuhc.com or www.365wellst.com or by calling the telephone number on your ID card. The list is subject to periodic review and modification.

Notification Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to notify

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the Claims Administrator or its designee. The reason for notification is to determine whether the Prescription Drug Product, in accordance with the Claims Administrator's approved guidelines, is each of the following:

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

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

The list of Prescription Drug Products requiring notification is subject to periodic review and modification. You may obtain a current list of Prescription Drug Products that require notification through the Internet at www.myuhc.com or www.365wellst.com or by calling the telephone number on your ID card.

If the Claims Administrator is not notified before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement as described in the Benefit Program Summary (Section 5: How to File a Claim).

When you submit a claim on this basis, you may pay more because you did not notify the Claims Administrator before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after the documentation provided is reviewed.

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What You Must Pay

You are responsible for paying the applicable Copayment described in the *Benefit Information* table, in addition to any Ancillary Charge when Prescription Drug Products are obtained from a retail or mail service Network Pharmacy.

The Ancillary Charge applies when a covered Prescription Drug Product is dispensed at your or the provider's request, when a chemically equivalent Prescription Drug Product is available on a lower Tier.

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

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

If prescription drugs are paid for in full at the time of purchase within 45 days of your eligibility effective date, payment will be based on the billed charge. If a prescription drug is purchased after the 45 days, your payment will be based on the contracted rate allowed for that prescription, minus the copayment.

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Payment Information

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

Description of Pharmacy Type and Supply Limits	Your Copayment Amount
Prescription Drugs from a Retail Network Pharmacy Benefits for outpatient Prescription Drug Products dispensed by a retail Network Pharmacy. The following supply limits apply: • As written by the provider, up to a consecutive 30-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.	Your Copayment is determined by the tier to which the Claims Administrator's Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access www.myuhc.com through the Internet, or call the Customer Service number on your ID card to determine tier status. $15 per Prescription Order or Refill for a **Tier-1 Prescription Drug Product.** $30 per Prescription Order or Refill for a **Tier-2 Prescription Drug Product.** $45 per Prescription Order or Refill for a **Tier-3 Prescription Drug Product.**

Send the Direct Claim Reimbursement Claim Form to:
Medco Health Solutions, Inc.
PO Box 2096
Lee Summit, MO 64063-7096

If you are planning a trip and will be leaving the country and need a Prescription Drug Product for an extended basis, the supply limits shown above will not apply. Contact Customer Service at (877) 842-2879 for more information.

Description of Pharmacy Type and Supply Limits	Your Copayment Amount
Prescription Drug Products from a Mail Service Network Pharmacy Benefits for outpatient Prescription Drug Products dispensed by a mail service Network Pharmacy. The following supply limits apply: • As written by the provider, up to a consecutive 30 to 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.	Your Copayment is determined by the tier to which the Claims Administrator's Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2 or Tier-3. Please access www.myuhc.com through the Internet, or call the Customer Service number on your ID card to determine tier status. **For up to a 30 day supply, your Copayment is:** $15 per Prescription Order or Refill for a **Tier-1 Prescription Drug Product.** $30 per Prescription Order or Refill for a **Tier-2 Prescription Drug Product.** $45 per Prescription Order or Refill for a **Tier-3 Prescription Drug Product.**
To receive the maximum Benefit, your provider must write your Prescription Order or Refill for the full 90 days.	**For up to a 30 to a 90 day supply, your Copayment is:** $30 per Prescription Order or Refill for a **Tier-1 Prescription Drug Product.** $60 per Prescription Order or Refill for a **Tier-2 Prescription Drug Product.** $90 per Prescription Order or Refill for a **Tier-3 Prescription Drug Product.**

Section 2: What's Not Covered--Exclusions

Exclusions from coverage listed in the Benefit Program Summary apply also to this Rider. In addition, the following exclusions apply:

1. Outpatient Prescription Drug Products obtained from a Non-Network Pharmacy.
2. Coverage for Prescription Drug Products for the amount dispensed (days supply or quantity limit) which exceeds the supply limit.
3. Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.
4. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental.
5. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
6. Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
7. Any product dispensed for the purpose of appetite suppression and other weight loss products.
8. A specialty medication Prescription Drug Product (such as immunizations and allergy serum) which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
9. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
10. General vitamins, except the following, which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
11. Medications used for cosmetic purposes.
12. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, which are determined to not be a Covered Health Service.
13. Prescription Drug Products when prescribed to treat infertility.
14. Glucose monitors.
15. Prescription Drug Products for smoking cessation.
16. Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill.
17. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug. Prescription Drug

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Products that are comprised of components that are available in over-the-counter form or equivalent, except as required to treat symptoms related to viral infections causing the common cold.

18. New Prescription Drug Products and/or new dosage forms until the date they are reviewed by our Pharmacy and Therapeutics Committee and approved by our Preferred Drug List Management Committee.
19. Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.
20. Lost, stolen or misplaced medications.
21. Drugs excluded from the formulary are never covered even when prescribed or deemed medically necessary by a physician. Medical Necessity will not overturn a denial in any situation for drugs, even in the event of an appeal.

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Section 3: Glossary of Defined Terms

This section:

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

Ancillary Charge – a charge, in addition to the Copayment, that you are required to pay for a covered Brand-name Prescription Drug Product which, at your or the provider's request, is dispensed when a Generic is available. (Generic substitution availability is identified on the Maximum Allowable Cost ("MAC") List.) **For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the contracted reimbursement rate for Network Pharmacies for the Prescription Drug Product dispensed, and the MAC List price of the Generic substitute.**

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

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

Maintenance Medications -a list, as the Claims Administrator designates, of Prescription Drug Products that are commonly prescribed by Physicians for long-term use. This list is subject to periodic review and modification. Contact the Claims Administrator to obtain a copy of the list of Maintenance Medications.

Maximum Allowable Cost (MAC) List – a list of Prescription Drug Products that will be covered at a Generic product price level that the Claims Administrator establishes. This list is subject to periodic review and modification.

Network Pharmacy – a pharmacy that has:

- Entered into an agreement with the Claims Administrator or its designee to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by the Claims Administrator as a Network Pharmacy.

A Network Pharmacy can be either a retail or a mail service pharmacy.

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

- The date it is approved by the Claims Administrator's Preferred Drug List Management Committee.
- December 31st of the following calendar year.

Preferred Drug List – a list that identifies those Prescription Drug Products which are preferred by the Claims Administrator for dispensing to Covered Persons when appropriate. This list is subject to periodic (at least quarterly) review and modification. Contact the Claims Administrator at the telephone number on your ID card to obtain a copy of the current Preferred Drug List or you can access it through the Internet at www.myuhc.com or www.365wellst.com.

Prescription Drug Cost – the rate the Claims Administrator has agreed to pay Network Pharmacies, including a dispensing fee and any sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

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

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:

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— insulin syringes with needles;

— blood testing strips – glucose;

— urine testing strips – glucose;

— ketone tablets and testing strips;

— lancets and lancet devices;

— insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets;

— glucagon emergency kits.

Prescription Order or Refill – the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Supply Limit - Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Section 1: What's Covered—Prescription Drug Benefits; pages 7, 8 and 9. For a single Copayment, you may receive a Prescription Drug Product up to the stated supply limit.

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

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

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Tier 1 – Your lowest cost option. For the lowest out-of-pocket expense, you should always consider Tier 1 medications if you and your doctor decide they are appropriate for your treatment.

Tier 2 – is your middle copayment option. Consider Tier 2 medications if you and your doctor decide that a Tier 2 medication is the most appropriate to treat your condition.

Tier 3 – is your highest copayment option. Sometimes there are alternatives available in Tier 1 or Tier 2. If you are currently taking a medication in Tier 3, ask your doctor whether there are Tier 1 or Tier 2 alternatives that may be appropriate for your treatment. Compounded medications, those medications containing one or more ingredients that are prepared "on-site" by a pharmacist, are covered under the pharmacy benefit.

Usual and Customary Charge – the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties.

- End of Outpatient Prescription Drug Rider -

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