

# Summary Plan Document

## 2014 Early Retiree Choice Plus Plan



Group Number: 707837  
Effective Date: July 1, 2014



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# Introduction

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

## How to Use this Document

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

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

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

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

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## Information about Defined Terms

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

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

## Your Contribution to the Benefit Costs

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

## Customer Service and Claims Submittal

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

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

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

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

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**Claims Submittal Address:**

United HealthCare Services, Inc.

Attn: Claims

P. O. Box 740809

Atlanta, Georgia 30374-0800

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

Name and Address For Submitting Requests:

United HealthCare Services, Inc.

P. O. Box 30573

Salt Lake City, Utah 84130-0573

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# Section 1: What's Covered--Benefits

This section provides you with information about:

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

## Accessing Benefits

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

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

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

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

Depending on the geographic area and the service you receive, you may have access to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, and if your Copayment is expressed as a percentage of Eligible Expenses for Non-Network Benefits, that percentage will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from other non-Network providers, because the Eligible Expense may be a lesser amount.

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## Copayment

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

## Eligible Expenses

Eligible Expenses for Covered Health Services, incurred while the Plan is in effect, are determined by us or by our designee. 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 is a Covered Health Service and how the Eligible Expense will be determined and otherwise covered under the Plan.

For Network Benefits, you are not responsible for any difference between the Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses.

## Pre-Authorization

Network Providers shall be responsible for complying with pre-authorization requirements, if any, set forth in the contract between

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the Network Providers and the Claims Administrator for the services listed below.

When utilizing a Non-Network Provider, it is recommended that you obtain pre-authorization for the services listed below.

Failure to obtain pre-authorization may result in a denial if the services are determined by a Physician not to be medically necessary or received in an inappropriate setting.

Pre-Authorization List:

- Home Health Care/Home Infusion Therapy
- Hospice Care
- Hospital Inpatient Stay
- Transplantation Services
- Care in a Skilled Nursing Facility

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

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

Network Providers shall be responsible for complying with pre-authorization requirements, if any, set forth in the contract between the Network Providers and the Claims Administrator for the services listed below.

When utilizing a Non-Network Provider, it is recommended that you obtain pre-authorization for the services listed below.

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Pre-Authorization List:

- Inpatient Hospital Stay
- Residential Treatment
- Partial Hospitalization/Day Treatment
- Intensive Outpatient
- Extended Outpatient Treatment Visits beyond 45-50 minutes in duration, with or without medication management
- Psychological Testing
- Outpatient Electro-convulsive Treatment
- CFIT – Child and Family Intensive Treatment Program
- Methadone Maintenance
- Ambulatory Detoxification
- MH/SU Crisis Stabilization
- MH/SU Home Care (IHBT)
- Applied Behavior Analysis for Autism Spectrum Disorder

The network facility must call the Mental Health/Substance Use Disorder Administrator before obtaining the Mental Health Services or Substance Use Disorder Services as described above. This call starts the utilization review process. Failure to obtain pre-authorization may result in a denial if the services are determined by the Mental Health/Substance Use Disorder Administrator not to be

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medically necessary or received in an inappropriate setting. The network provider, not the member, will be responsible if preauthorization was not obtained and the services are denied.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

The Mental Health/Substance Use Disorder Administrator performs utilization review to determine whether the requested service is a Covered Health Service. The Mental Health/Substance Use Disorder Administrator does not make treatment decisions about the kind of behavioral health care you should or should not receive. You and your provider must make those treatment decisions.

If you receive the above services from a non-network provider it is your responsibility to call the Mental Health/Substance Use Disorder Administrator before obtaining the Mental Health Services or Substance Use Disorder Services as previously described. If you do not receive prior authorization, and the Mental Health/Substance Use Disorder Administrator determines the services not to be medically necessary or were received in an inappropriate setting, you may be responsible for paying all charges and no Benefits will be paid. The Customer Service phone number for the Mental Health/Substance Use Disorder and Plan Administrator appears on your ID card.

Only Emergency Mental Health and Substance Use Disorder services will be eligible for retroactive authorization at the sole discretion of the Contract Administrator.

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### ***Special Note Regarding Medicare***

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

## **Coverage While Traveling Abroad**

The Plan pays Benefits for Covered Persons while traveling outside the United States. Eligible Expenses for non-Emergency services incurred while outside the United States are reimbursed at the Non-Network benefit level. If you receive treatment while traveling outside the United States, you will have to pay for the services up-front and then submit a claim form along with the receipt and an itemized bill from the provider. For details on the procedures for filing a claim, refer to Sections 5, *How to File a Claim* and Section 6, *Questions, Complaints, Adverse Benefit Determinations and Appeals*. If you have any questions about Benefits while traveling abroad, please call UnitedHealthcare at the toll-free number on your ID card.

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## Payment Information

Payment Term	Description	Amounts
<b>Annual Deductible</b>	The amount you pay for Covered Health Services before you are eligible to receive Benefits.	<u><i>Network</i></u> No Annual Deductible.
		<u><i>Non-Network</i></u> No Annual Deductible.
<b>Out-of-Pocket Maximum</b>	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.	<u><i>Network</i></u> \$3,000 per Covered Person per calendar year, not to exceed \$9,000 for all Covered Persons in a family.
		<u><i>Non-Network</i></u> \$3,000 per Covered Person per calendar year, not to exceed \$9,000 for all Covered Persons in a family.

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

# Benefit Information

Description of Covered Health Service	Your Copayment Amount	Does Copayment Help Meet Out-of-Pocket Maximum?
<b>1. Ambulance Services</b>		
<i>Ground Ambulance</i>		
Local professional or municipal ground ambulance services are covered when it is medically necessary to use these services, rather than any other form of transportation, to the following destinations:	<p data-bbox="1262 297 1482 375"><small>% Copayments are based on a percent of Eligible Expenses</small></p> <p><i>Ground Transportation:</i> No Copayment</p>	No
<ul style="list-style-type: none"> <li>(a) to the closest available Hospital for an inpatient admission;</li> <li>(b) from a Hospital to home or to a Skilled Nursing Facility after being discharged as an inpatient;</li> <li>(c) to the closest available Hospital emergency room immediately in an emergency; OR</li> <li>(d) to and from a Hospital for medically necessary services not available in the Hospital where you are an inpatient.</li> </ul>	<p><i>Air and Water Transportation:</i> No Copayment up to a \$3,000 Maximum Benefit per occurrence</p>	
Our allowance for the ground ambulance includes attendant services, drugs, supplies and cardiac monitoring.	<p><u><i>Non-Network</i></u></p> <p><i>Ground Transportation:</i> No Copayment</p>	No
	<p><i>Air and Water Transportation:</i> No Copayment up to a \$3,000 Maximum Benefit per occurrence</p>	

**Description of  
Covered Health Service**

**Your Copayment  
Amount**

% Copayments are  
based on a percent of  
Eligible Expenses

**Does  
Copayment  
Help Meet  
Out-of-Pocket  
Maximum?**

---

***Air/Water Ambulance***

Medically necessary air and water ambulance services are covered up to the maximum amount of \$3,000 per occurrence.

Air ambulance service involves transportation by means of a helicopter or fixed wing aircraft. The aircraft must be a certified ambulance and the crew, maintenance support crew and aircraft must meet the certification requirements and hold a certificate for air ambulance operators under Part 135 of the Federal Aviation Administration (FAA) regulations.

Water ambulance involves transportation by means of a boat. The boat must be specially designed and equipped for transporting the sick or injured and it must also have such other safety and lifesaving equipment as is required by state or local authorities.

Use of an air/water ambulance is medically necessary when the time needed to transport a patient by land, or the instability of transportation by land, poses a threat to the patient's condition or survival or the proper equipment required to treat the patient is not available on a land ambulance.

The patient must be transported for treatment to the nearest appropriate facility that is capable of providing a level of care for the patient's illness and that has available the type of Physician needed to treat the patient's condition.

**Description of  
Covered Health Service**

**Your Copayment  
Amount**

% Copayments are  
based on a percent of  
Eligible Expenses

**Does  
Copayment  
Help Meet  
Out-of-Pocket  
Maximum?**

---

This Plan will only cover air and water ambulance services originating and terminating in the United States and its territories. Our allowance for the air/water ambulance includes attendant services, drugs, supplies and cardiac monitoring.

***Related Exclusions***

Air/water ambulance is NOT covered for transport to a facility that is not an acute care Hospital, such as a Physician's office, nursing facility, or the patient's home.

This Plan does NOT provide coverage for transport from cruise ships when not in United States waters.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<p><b>2. Cancer Resource Services</b></p> <p>Cancer Resource Services is a voluntary program in which you will receive assistance in obtaining care that is planned, coordinated and provided by a team of experts who specialize in your specific cancer. We will arrange for access to certain of our Network providers that participate in the Cancer Resource Services program for the provision of oncology services. We may refer you to Cancer Resource Services, or you may self refer to Cancer Resource Services by calling 866-936-6002. 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.</p>	<p><u>Network</u> Cancer Resource Services must be called.</p>	<p>No Copayment</p>
<p>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.</p>	<p><u>Non-Network</u> Non-Network Benefits for the Cancer Resource Services program are not available.</p>	<p>Non-Network Benefits for the Cancer Resource Services program are not available.</p>
<p>When these services are not performed in a Cancer Resource Services facility, Benefits will be paid the same as Benefits for <i>Hospital-Inpatient Stay, Outpatient Surgery, Diagnostic and Therapeutic Services, Physician's Office Services, and Professional Fees for Surgical and Medical Services</i> stated in this (Section 1: What's Covered--Benefits).</p>	<p>Non-Network Benefits for the Cancer Resource Services program are not available.</p>	<p>No</p>

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<h3>3. Clinical Trials – Routine Patient Care Costs</h3>	<u>Network</u>	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Diagnostic and Therapeutic Services.
<p>Benefits are available for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.</p>	<u>Non-Network</u>	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Diagnostic and Therapeutic Services.
<p>Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying Clinical Trial.</p>		
<p>Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying Clinical Trial as defined by the researcher.</p>		
<p>Routine patient care costs for qualifying Clinical Trials include:</p>		
<ul style="list-style-type: none"> <li>• Covered Health Services for which Benefits are typically provided absent a Clinical Trial;</li> <li>• Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the service or item, or the prevention of complications; and</li> </ul>		
<p>Routine costs for Clinical Trials do not include:</p>		

**Description of  
Covered Health Service**

**Your Copayment  
Amount**  
% Copayments are  
based on a percent of  
Eligible Expenses

**Does  
Copayment  
Help Meet  
Out-of-Pocket  
Maximum?**

- the Experimental or Investigational Service(s) or item. The only exceptions to this are:
  - certain *Category B* devices;
  - certain promising interventions for patients with terminal illnesses; and
  - other items and services that meet specified criteria in accordance with the Claims Administrator’s medical and drug policies;
- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV Clinical Trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<ul style="list-style-type: none"> <li>• Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following: <ul style="list-style-type: none"> <li>— National Institutes of Health (NIH). (Includes National Cancer Institute (NCI));</li> <li>— Centers for Disease Control and Prevention (CDC);</li> <li>— Agency for Healthcare Research and Quality (AHRQ);</li> <li>— Centers for Medicare and Medicaid Services (CMS);</li> <li>— a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA);</li> <li>— a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or</li> <li>— The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria: <ul style="list-style-type: none"> <li>◆ comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and</li> <li>◆ ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.</li> </ul> </li> </ul> </li> </ul>		

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<ul style="list-style-type: none"> <li>the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;</li> <li>the study or investigation is a drug trial that is exempt from having such an investigational new drug application;</li> <li>the Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. We may, at any time, request documentation about the trial; or</li> <li>the subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.</li> </ul>		

#### 4. Chiropractic Treatment

Benefits for Chiropractic Treatment when provided by a Chiropractic Treatment provider in the provider's office.

Benefits include diagnosis and related services and are limited to one visit and treatment per day.

Any combination of Network and Non-Network Benefits for Chiropractic Treatment, regardless of the place of service, is limited to 12 visits per calendar year.

Network

\$25 per visit

Yes

Non-Network

20%

Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<p><b>5. Contraceptive Devices</b></p> <p>Benefits for Contraceptive Devices for all F.D.A. approved devices requiring a Physician's order including:</p> <p>Surgical implantation and removal of I.U.D.'s and contraceptive implants such as, but not limited to, Norplant pellets.</p> <p>Diaphragms supplied in a Physician's office are covered as a medical supply and are subject to the allowances for durable medical equipment.</p> <p>Injectable contraceptive drugs administered by a Physician in a Physician's office.</p>	<u>Network</u>	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Diagnostic, injections received in a physician's office, durable medical equipment, and Therapeutic Services.
	<u>Non-Network</u>	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, and Outpatient Diagnostic, injections received in a physician's office, durable medical equipment, and Therapeutic Services.
<p><b>6. Dental Services - Accident only</b></p> <p>Dental services when all of the following are true:</p> <ul style="list-style-type: none"> <li>• Treatment is necessary because of accidental damage.</li> <li>• Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D."</li> <li>• The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident.</li> </ul>	<u>Network</u>	No Copayment                      No

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<p>Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was:</p> <ul style="list-style-type: none"> <li>• A virgin or unrestored tooth, or</li> <li>• A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.</li> </ul>	<u><i>Non-Network</i></u>	Same as Network
<p>Only the following services are covered:</p> <ul style="list-style-type: none"> <li>• Extraction of teeth needed to avoid infection of teeth damaged in the injury;</li> <li>• Suturing and suture removal;</li> <li>• Reimplanting and stabilization of dislodged teeth;</li> <li>• Repositioning and stabilization for partly dislodged teeth; and</li> <li>• Medication received from the provider.</li> </ul>		
<p>Note that suture removal performed when the original emergency dental services were received is covered as part of our allowance for the original dental emergency treatment. This plan only covers a separate charge for suture removal if the suturing and suture removal are performed at different locations (i.e., sutures at emergency room and suture removal at physician's office).</p>		
<p>Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not</p>		

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities.		
<b>7. Diabetes Services</b>		
Services and supplies for the diagnosis or treatment of insulin treated diabetes, non-insulin treated diabetes and gestational diabetes, including:	<u>Network</u>	
<ul style="list-style-type: none"> <li>• Insulin pumps and insulin pump supplies.</li> <li>• Insulin infusion devices.</li> <li>• Therapeutic/molded shoes for the prevention of amputation. Limited to 2 pair of shoes or 4 individual shoes per calendar year. Includes inserts up to 2 pairs of inserts per pair of shoes or 2 inserts if only one shoe is dispensed. Additional inserts for depth shoes are covered up to 3 pairs of inserts per pair of shoes or three inserts if only one shoe is dispensed.</li> <li>• Syringes and Diabetic test strips.</li> <li>• Blood glucose monitors, including for those individuals who are legally blind.</li> <li>• Injection aids, cartridges for the legally blind and oral agents for controlling blood sugar.</li> <li>• Supplies and equipment approved by the FDA for the purposes for which they have been prescribed.</li> </ul>	<u>Inpatient</u> No Copayment for equipment and supplies	Yes, for Outpatient Services
	<u>Outpatient</u> 20% for equipment and supplies	
	\$25 per visit for diabetes self-management education	
	<u>Non-Network</u>	
	20%	Yes
Diabetes outpatient self-management training and education, including medical nutrition therapy, when provided by a certified		

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<p>diabetes health care provider.</p> <p>If more than one piece of Durable Medical Equipment for the treatment of diabetes can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment.</p>		

## 8. Diagnostic Services

### *Diagnostic Services*

Covered Health Services received on an inpatient, outpatient, or in a physician's office including:

- Lab and radiology/X-ray, including Imaging Electrocardiograms (EKGs), Electroencephalograms (EEGs), ultrasonography (ultrasound); audiometric hearing and speech tests, blood tests and typing, urinalysis, and nose/throat cultures.
- Mammography testing and pap smears in accordance with current American Cancer Society guidelines. Additionally, two mammograms will be covered per year when recommended by a physician for women who have been treated for breast cancer within the last five (5) years or are at high risk of developing breast cancer due to genetic predisposition (BRCA gene mutation or multiple first degree relatives) or high risk lesion on prior biopsy (lobular carcinoma in situ) or atypical ductal hyperplasia.

Network

*For lab and radiology/  
X-ray:*

No Copayment

No

*For  
mammography  
testing:*

No Copayment

No

Description of Covered Health Service	<u>Non-Network</u>	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<ul style="list-style-type: none"> <li>• Prostate and colorectal examinations and laboratory tests in accordance with current American Cancer Society guidelines</li> <li>• Computerized Axial Tomography CT scans, Pet scans, MRI, and nuclear medicine.</li> <li>• Magnetic Resonance Angiography (MRA) of head and neck when you are suspected of having the following: <ul style="list-style-type: none"> <li>• Steno-occlusive disease of the mid or large size intracranial arteries;</li> <li>• Cerebral aneurysms;</li> <li>• Intracranial vascular malformation;</li> <li>• Cerebral venous sinus compression or thrombosis;</li> <li>• Pulsatile tinnitus;</li> <li>• Carotid stenosis or occlusion;</li> <li>• Cervicocranial arterial dissection.</li> </ul> </li> </ul>		20%	Yes

This plan covers doctor services for the initial reading or initial interpretation of the diagnostic machine tests and x-rays listed above when billed by a doctor. This plan covers the pathologist's initial reading and interpretation of Pap Smear results.

Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.

Note that pathological examinations performed in a hospital are

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only covered by this plan when billed by the hospital.

***Outpatient Therapeutic Treatments***

Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, radiation and other treatments not listed above.

**Outpatient Radiation Therapy:** This plan covers hospital and doctor services for outpatient radiation therapy. Radiation physics, dosimetry services, treatment devices, and hospital services are included in radiation treatment planning and therapy and are covered as part of our allowance for radiation therapy.

**Outpatient Chemotherapy:** This plan covers the doctor's administration fee and associated hospital supplies for infused anti-neoplastic prescription drugs used for the treatment of cancer.

Outpatient hemodialysis must be received in a hospital's outpatient unit or in an approved hemodialysis facility.

This Plan covers the following services for treatment of hemophilia:

- Yearly evaluation;
- Medically necessary visits;
- Hemophilia outpatient physical therapy up to 56 treatments per calendar year;
- Clotting factor drugs; AND

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<ul style="list-style-type: none"> <li>Supplies.</li> <li>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i>.</li> </ul>		
<h3>9. Durable Medical Equipment</h3>		
<p>Durable Medical Equipment that meets each of the following criteria:</p>		
<ul style="list-style-type: none"> <li>Ordered or provided by a Physician for outpatient use.</li> <li>Used for medical purposes.</li> <li>Not consumable or disposable.</li> <li>Not of use to a person in the absence of a disease or disability.</li> </ul>	<u>Network</u>	<u>Inpatient</u> No Copayment
		No
		<u>Outpatient</u> 20% Yes
	<u>Non-Network</u>	<u>Inpatient</u> 20% Yes
<p>If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment.</p>		
<p>Examples of Durable Medical Equipment include:</p>		
<ul style="list-style-type: none"> <li>Equipment to assist mobility, such as a standard wheelchair.</li> <li>A standard Hospital-type bed.</li> <li>Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).</li> <li>Delivery pumps for tube feedings (including tubing and connectors).</li> </ul>		<u>Outpatient</u> 20% No

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<ul style="list-style-type: none"> <li>• Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part, braces to treat curvature of the spine, and cranial orthosis or helmet and Hi-Knee-Ankle-Foot-Orthosis (HKAFO) are considered Durable Medical Equipment and are Covered Health Services. Other braces that straighten or change the shape of a body part, dental braces, and shoe and foot orthotics are excluded from coverage.</li> <li>• Essential accessories such as hoses, tubes, and mouthpieces for necessary durable medical equipment ONLY if you own the equipment (these accessories are included as part of the rental allowance for rental equipment).</li> <li>• Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).</li> <li>• Ostomy supplies include only the following: pouches, face plates, and belts. Irrigation sleeves, bags and catheters. Skin barriers. Benefits are not available for gauze, adhesive, adhesive remover, deodorant, pouch covers or other items not listed above.</li> <li>• Contact lenses or glasses following cataract surgery.</li> <li>• Diaphragms supplied in a Physician's office.</li> <li>• Custom ordered compression stockings are only covered when prescribed by a physician. Limit is (4) pairs of stockings, up to (8) units in a calendar year. "Over the counter" stockings are</li> </ul>		

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<p>not covered, nor stockings for prosthetics.</p> <ul style="list-style-type: none"> <li>External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See <i>Hospital – Inpatient Stay, Rehabilitative Services – Outpatient Therapy</i> and <i>Surgery – Outpatient</i> in this section.</li> </ul> <p>The Claims Administrator will decide if the equipment should be purchased or rented. You must purchase or rent the Durable Medical Equipment from the vendor the Claims Administrator identifies.</p> <p>Repairs to rental equipment are an expense of the vendor; repairs to equipment you own are your liability. Note: Regular batteries or specialized batteries necessary for equipment are NOT covered.</p>		
<p><b>10. Early Intervention Services</b></p> <p>Benefits are payable for preventive and primary services for a Dependent child younger than three years of age who is certified by the department of human services as eligible for early intervention services. Covered Health Services include, but are not limited to, the following:</p>	<u>Network</u>	No Copayment      No
<ul style="list-style-type: none"> <li>Occupational therapy.</li> <li>Speech therapy.</li> <li>Physical therapy.</li> </ul>	<u>Non-Network</u>	No Copayment      No

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<ul style="list-style-type: none"> <li>• Evaluation.</li> <li>• Case Management.</li> <li>• Service plan development and review.</li> <li>• Nursing care.</li> <li>• Nutritional services.</li> <li>• Psychological counseling.</li> <li>• Assistive technology services and devices consistent with early intervention programs approved by the Department of Health.</li> </ul> <p>Early intervention services must be given by a licensed provider designated by the Department of Human Services as an "early intervention provider" and who works in early intervention programs approved by the Department of Health.</p>		

## 11. Emergency Health Services

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits include the facility charge, supplies and all professional services. This includes placement in a Hospital bed to monitor your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Network

\$125 per visit  
Copayment  
waived if  
admitted to  
Hospital within  
24 hours or for  
an Observation  
stay.

Yes

Description of Covered Health Service	<u>Non-Network</u>	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<p>Follow-up visits to the emergency room are not covered.</p> <p>You will find more information about Benefits for Emergency Health Services in (Section 3: Description of Network and Non-Network Benefits).</p>	<u>Non-Network</u>	Same as Network	Yes
<b>12. Enteral Nutrition Products</b>			
<p>Non-prescription enteral formulas for home use as medically necessary and ordered in writing by a</p>	<u>Network</u>	No Copayment	No
<p>Physician for the treatment of malabsorption caused by:</p>	<u>Non-Network</u>	20%	Yes
<ul style="list-style-type: none"> <li>• Crohn's disease.</li> <li>• Ulcerative colitis.</li> <li>• Gastrosophageal reflux.</li> <li>• Chronic intestinal pseudo-obstruction</li> </ul>			
<p>Inherited diseases of amino acids and organic acids including food products modified to be low protein.</p>			
<b>13. Habilitative Services (Effective 07/01/14)</b>			
<p>Benefits are provided for habilitative services provided on an outpatient basis for Covered Persons with a congenital, genetic, or early acquired disorder when both of the following conditions are</p>	<u>Network</u>	No Copayment applies for Physical or Occupational therapy within 30 days following a	Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<p>met:</p> <ul style="list-style-type: none"> <li>The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.</li> <li>The initial or continued treatment must be proven and not Experimental or Investigational.</li> </ul> <p>Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.</p> <p>The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed and that the Covered Person's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, we</p>	<p>related Hospital stay, home care program, or ambulatory surgical procedure, otherwise 20%. 20% applies to Speech therapy outpatient or physician's office</p> <p><b><u>Non-Network</u></b></p> <p>20%</p>	<p>Yes, if therapy is within 30 days following a related hospital stay, home care program or ambulatory surgical procedure, otherwise No.</p>

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may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, the following definitions apply:

- "Habilitative services" means occupational therapy, physical therapy and speech therapy prescribed by the Covered Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.
- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.
- An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by a Covered Person prior to that Covered Person developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorders.

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Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<b>14. Hearing Aids (Effective 01/01/12)</b>		
Coverage for a Hearing Aid must be ordered by a Physician and is limited to \$5,000 in Eligible Expenses per year. Benefits are limited to a single purchase (including repair/replacement) every 3 years.	<u>Network</u>	20% Yes
<u>"Hearing Aid"</u> - Any non-experimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, but excluding batteries, cords, and other assistive listening devices, including, but not limited to FM systems.	<u>Non-Network</u>	20% Yes
<b>15. Home Health Care</b>		
Services received from a Home Health Agency that are medically necessary and are as follows:	When part of a coordinated home care program:	
<ul style="list-style-type: none"> <li>• Ordered by a Physician.</li> <li>• The program is formulated and supervised by the Participant's Physician; and</li> <li>• Provided by or overseen by a registered nurse or provided by a home health aid in your home.</li> </ul>	<u>Network</u>	No Copayment No
Benefits are available only when the Home Health Agency services are provided on a full-time, part-time, intermittent schedule and when skilled care is required.	<u>Non-Network</u>	20% Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
Preauthorization is recommended.		
Benefits are available for the following services:		
<ul style="list-style-type: none"> <li>• Physical/Occupational therapy: must be received from a licensed physical or occupational therapist and through a pre-authorized home care program.</li> <li>• Speech therapy.</li> <li>• Respiratory services.</li> <li>• Medical social work.</li> <li>• Nutritional counseling.</li> <li>• Prescription drugs and medications.</li> </ul>	When not part of a coordinated home care program:	
	<u>Network</u>	
	20%	Yes
<ul style="list-style-type: none"> <li>• Medical and surgical supplies.</li> <li>• Minor equipment such as commodes and walkers.</li> <li>• Laboratory and X-ray services, E.E.G. and E.K.G. evaluations.</li> <li>• Home infusion therapies. The following services are covered: <ul style="list-style-type: none"> <li>• nursing visits billed by the agency;</li> <li>• total enteral nutrition;</li> <li>• hydration therapy; antibiotic therapy;</li> <li>• enteral nutrition;</li> <li>• human growth hormone;</li> <li>• pentamidine;</li> </ul> </li> </ul>	<u>Non-Network</u>	
	20%	Yes

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- immunoglobulin;
- chelation;
- drugs relating directly to the home infusion therapy;
- solutions;
- related equipment;
- supplies; and
- the services of the home infusion nurse.

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

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

A service will not be determined to be "skilled" simply because there is not an available caregiver. Please contact the Claims Administrator for more information regarding guidelines for home

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
health care. You can contact the Claims Administrator at the telephone number on your ID card.		
<b>Note:</b> This plan does NOT cover radiation treatment services received in your home. This plan covers oral and injectable anti-neoplastic prescription drugs when they have been approved by us and are used solely for the purpose of cancer treatment.		
<b>16. Hospice Care</b>		
Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available when hospice care is received from an approved hospice agency.	<u>Network</u>	No Copayment
If you have a terminal illness and you agree with your doctor not to continue with a curative treatment program, this plan covers some hospice care services provided by an approved hospice care program, as set forth in this section.		No
This plan covers the following services and supplies received through an approved hospice care program.	<u>Non-Network</u>	20%
<ul style="list-style-type: none"> <li>• services of a hospice coordinator billed by the hospice care program;</li> <li>• services of a visiting nurse when billed by a visiting nurse agency; AND</li> </ul>		Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	
<ul style="list-style-type: none"> <li>services of a home health aide.</li> </ul> <p>Please contact the Claims Administrator for more information regarding guidelines for hospice care. You can contact the Claims Administrator at the telephone number on your ID card.</p> <p>Preauthorization is recommended for Non-Network care.</p>			
<b>17. Hospital - Inpatient Stay</b>			
Inpatient Stay in a Hospital. Benefits are available for:	<u>Network</u>	No Copayment	No
<ul style="list-style-type: none"> <li>Supplies and non-Physician Hospital services received during the Inpatient Stay.</li> <li>Room and board in a Semi-private Room (a room with two or more beds).</li> </ul>			
Benefits for Physician services are described under <i>Professional Fees for Surgical and Medical Services</i> .	<u>Non-Network</u>	20%	Yes
<p>This plan covers inpatient hospitalization in a General Hospital for an unlimited number of days. Combined Network and Non-Network Benefits at Specialty Hospitals or in a General Hospital for specialty services are limited to 45 days per calendar year. If you are readmitted after ninety (90) days, we consider this to be a new period of hospitalization for the purpose of determining the hospital days available to you.</p> <p>Preauthorization is recommended at non-network facilities.</p>			

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<b>18. Infertility Services (Effective 7/01/07)</b>	<u>Network</u>	20%
Services for the diagnosis and treatment of infertility for women when provided by or under the direction of a Physician and deemed medically necessary.		Yes
Includes oral or injectable infertility drugs not obtained at the pharmacy.		
Infertility is defined as a condition of an otherwise presumably healthy married individual who is unable to conceive or sustain a pregnancy during a period of one year.	<u>Non-Network</u>	20%
Benefits also include:		Yes
<ul style="list-style-type: none"> <li>• Oral and injectable infertility drugs not obtained at the pharmacy.</li> <li>• Donor gametes if provided through an approved program; if: <ul style="list-style-type: none"> <li>— Married; and</li> <li>— Unable to conceive or sustain a pregnancy during a one year period.</li> </ul> </li> </ul>		

Description of Covered Health Service	<u>Network</u>	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<p><b>19. Injections received in a Physician's Office</b></p> <p>Benefits are available for injections received in a Physician's office.</p> <p>Tetanus injections are a covered benefit, and Injections for Rabies following an exposure are a covered benefit.</p> <p>Immunizations for adults: Hepatitis B injections are covered if there is a risk</p>	<u>Network</u>	No Copayment	No
	<u>Non-Network</u>	20% per injection	Yes
<p><b>20. Lyme Disease</b></p> <p>Coverage for diagnostic testing and long-term antibiotic treatment of chronic lyme disease when determined to be medically necessary and ordered by a physician after making a thorough evaluation of the patient's symptoms, diagnostic test results and response to treatment. Treatment otherwise eligible for benefits pursuant to this section shall not be denied solely because such treatment may be characterized as unproven, experimental, or investigational in nature.</p>	<u>Network</u>	No Copayment	No
	<u>Non-Network</u>	No Copayment	No

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<p><b>21. Maternity Services</b></p> <p>Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This plan covers physician services (including the services of a licensed midwife) for all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. Physician and midwife services combined are not covered for more than our allowance.</p> <p>This includes newborn screening tests for metabolic, endocrine and hemoglobinopathy disorders.</p> <p>There are special prenatal programs to help during Pregnancy, including hospital-based classes on breastfeeding, caring for your infant and early pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify the Claims Administrator during the first trimester, but no later than one month prior to the anticipated childbirth.</p> <p>We will pay Benefits for an Inpatient Stay of at least:</p> <ul style="list-style-type: none"> <li>• 48 hours for the mother and newborn child following a normal vaginal delivery.</li> <li>• 96 hours for the mother and newborn child following a cesarean section delivery.</li> <li>• One lactation support out-patient visit or home visit is covered when ordered by the child's physician. Appointment must occur within 7 days after hospital discharge.</li> </ul>	<p><u>Network</u></p>	<p>Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Preventive Care Services and Outpatient Diagnostic and Therapeutic Services.</p> <p>No Copayment applies to Physician office visits for prenatal care after the first visit in which a \$25 copayment applies.</p>

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<p>If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. This decision shall be made in accordance with the standards for guidelines for prenatal care published by the American College of Obstetrics and Gynecology and the American Academy of Pediatrics.</p>	<u><i>Non-Network</i></u>	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.
<p>In those cases where you and your infant participate in an early discharge, you will be eligible for:</p>		
<ul style="list-style-type: none"> <li>(a) 2 home care visits by a skilled, specially trained registered nurse for you and/or your infant, and additional visits reviewed by a Physician for medical necessity;</li> <li>(b) Parent education, assistance and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests or any other tests or services related thereto; and</li> <li>(c) A pediatric office visit within 24 hours after discharge.</li> </ul>		
<p>The newborn is automatically covered for the first 31 days (this does not include newborns of dependent children).</p>		

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<b>22. Mental Health</b>	<u>Network</u>	
Mental Health Services include those received on an inpatient or Intermediate Care basis in a Hospital or at an Alternate Facility, and those received on an outpatient basis in a provider’s office or at an Alternate Facility.	<u>Hospital Inpatient Stay</u> No Copayment	No
Some services require Pre-Authorization. Please see “Section 1, Pre-Authorization”, for detailed information. Without prior authorization for the non-network services specified in Section 1, you may be responsible for paying all charges and no Benefits will be paid.	<u>Physician’s Office Services</u> \$15 per visit	Yes
Benefits include the following services provided on either an outpatient or inpatient basis:		
<ul style="list-style-type: none"> <li>• Diagnostic evaluations and assessment.</li> <li>• Mental health evaluations and assessment.</li> <li>• Treatment planning.</li> <li>• Referral services.</li> <li>• Medication management.</li> <li>• Inpatient services.</li> <li>• Partial hospitalization/day treatment.</li> <li>• Individual, family and therapeutic group and provider-based case management services.</li> <li>• Crisis intervention.</li> </ul>		

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
Benefits include the following services provided on an inpatient basis:	<u><i>Non-Network</i></u>	
<ul style="list-style-type: none"> <li>• Partial Hospitalization/Day treatment.</li> <li>• Services at a Residential Treatment Facility.</li> </ul>	<u><i>Hospital Inpatient Stay</i></u> 20%	Yes
Benefits include the following services on an outpatient basis:		
<ul style="list-style-type: none"> <li>• Intensive outpatient treatment.</li> </ul>	<u><i>Physician's Office Services</i></u> 20%	Yes
If an Inpatient Stay is required, it is covered on a Semi-private Room basis.		
This plan covers the following outpatient mental health specialists and services up to the maximum number of visits listed above.		
<ul style="list-style-type: none"> <li>• Board certified psychiatrists; licensed clinical psychologists, clinical social workers (licensed or certified at the Independent practice level – “Certified Independent Social Worker”);</li> <li>• Licensed nurse clinicians (with MRN degrees and certification by the ANA as a clinical specialist in psychiatric and mental health nursing); AND</li> <li>• Licensed Marriage and Family Therapists.</li> </ul>		
The above providers must be licensed and certified in the state where you receive the service and must meet our credentialing criteria.		

**Description of  
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Maximum?**

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**Day Care:**

This Plan covers the following psychiatric day care services for eight (8) hours a day in an approved psychiatric day care program. It must be medically necessary that you receive supervised care through that program two or more times per week for a continuous eight (8) hour period each time:

- Appropriate Hospital services;
- Professional and other staff services performed by employees of the facility under the supervision of a staff psychiatrist; AND
- A maximum of four (4) family therapy sessions for members of your family with mental health professionals employed by the facility.

**Transitional Outpatient Services:**

Transitional outpatient services are used as a step down from a higher level of care or a step-up from standard outpatient care. This Plan covers the following outpatient services:

- **Intensive Outpatient Program** - Individual and group therapy with medication management for a minimum of three (3) hours per day, normally three (3) days per week. This program provides substantial clinical support for patients who are either in transition from the Hospital to any outpatient setting or at risk for admission to inpatient care or other higher levels of care.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<ul style="list-style-type: none"> <li>• <b>Adult and Child Intensive Services</b> - Services include up to seven (7) visits per week, consisting of ongoing emergency/crisis evaluations, psychiatric assessment, medication evaluation, case management, nursing services, and outpatient therapy.</li> <li>• <b>Facility Home Based Treatment</b> - Individual or family therapy and/or medication management provided in the patient's home.</li> </ul>		

**Shock Therapy**

This Plan covers electroshock therapy services when performed and billed by a Physician. This Plan does NOT cover Physician visits and outpatient mental health visits on the same day that electroshock therapy was performed. Anesthesia administered to you for shock therapy is covered provided it is not administered by the same Physician who is performing the shock therapy.

**23. Substance Use Disorder Services**

Substance Use Disorder Services include those received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Some services require Pre-Authorization. Please see "Section 1, Pre-Authorization", for detailed information. Without prior authorization for the non-network services specified in Section 1, you may be responsible for paying all charges and no Benefits will

Network

Hospital Inpatient Stay  
No Copayment

No

Physician's Office Services  
\$15 per visit

Yes

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be paid.

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

- Diagnostic evaluations and assessment.
- Treatment Planning.
- Detoxification (sub-acute / non-medical).
- Referral services.
- Medication management.
- Individual, family therapeutic group and provider based case management.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

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

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
If an Inpatient Stay is required, it is covered on a Semi-private Room basis.	<p><u><i>Non-Network</i></u></p> <p><u><i>Hospital Inpatient Stay</i></u> 20%</p> <p><u><i>Physician's Office Services</i></u> 20%</p>	<p>Yes</p> <p>Yes</p>
<p><b>24. Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders</b></p>	<p><u><i>Network</i></u></p> <p><u><i>Physician's Office Services</i></u> \$15 per visit</p>	<p>Yes</p>
<p>The Plan pays for Benefits for psychiatric services for Autism Spectrum Disorders that are all of the following:</p>	<ul style="list-style-type: none"> <li>• Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and</li> <li>• Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others, and property and impairment in daily functioning.</li> <li>• Consistent with Rhode Island General Law.</li> </ul>	

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Some services require Pre-Authorization. Please see “Section 1, Pre-Authorization”, for detailed information. Without prior authorization for the non-network services specified in Section 1, you may be responsible for paying all charges and no Benefits will be paid.

An individual providing ABA services must be:

- Individually licensed by the State of Rhode Island Department of Health as a healthcare provider/clinician and nationally certified as a Board Certified Behavior Analyst (BCBA); or
- Individually nationally certified as a Board Certified Assistant Behavior Analyst
- (BCaBA) supervised by a Board Certified Behavior Analyst who is licensed by the State of Rhode Island Department of Health as a psychologist, social worker or therapist.

For Network Benefits, the individual providing ABA service must also be a Network provider.

These Benefits describe only the psychiatric component of treatment for autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this document.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
Benefits include the following services provided on an outpatient basis:	<u>Non-Network</u>	<u>Physician's Office Services</u> 20%
<ul style="list-style-type: none"> <li>• Diagnostic evaluations and assessment.</li> <li>• Treatment planning.</li> <li>• Referral services.</li> <li>• Medication management.</li> <li>• Individual, family, therapeutic group and provider-based case management services.</li> <li>• Crisis intervention.</li> </ul>		Yes
Benefits include the following services provided on an outpatient basis:		
<ul style="list-style-type: none"> <li>• Intensive Outpatient Treatment.</li> </ul>		
Covered Health Services include enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as Applied Behavioral Analysis (ABA).		

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<p><b>25. Nutritional Counseling</b></p> <p>Nutritional Counseling medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:</p> <ul style="list-style-type: none"> <li>Nutritional education is required for a disease in which patient self-management is an important component of treatment.</li> <li>There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.</li> </ul>	<u>Network</u>	No Copayment No
<p>Benefits are limited to six visits per calendar year and must be prescribed by a Physician.</p> <p>Examples of such medical conditions include, but are not limited to:</p> <ul style="list-style-type: none"> <li>Diabetes mellitus.</li> <li>Morbid obesity.</li> <li>Coronary artery disease.</li> <li>Congestive heart failure.</li> <li>Severe obstructive airway disease.</li> <li>Gout.</li> <li>Renal failure.</li> <li>Phenylketonuria.</li> <li>Hyperlipidemias.</li> </ul>	<u>Non-Network</u>	20% Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<ul style="list-style-type: none"> <li>• Celiac disease.</li> <li>• Irritable Bowel Syndrome.</li> <li>• Obesity.</li> <li>• Family history of ischemic heart disease.</li> <li>• Family history of other cardiovascular diseases.</li> </ul>		

## 26. Outpatient Surgery and Therapeutic Services

### *Outpatient Surgery*

Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

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

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

### Network

No Copayment

No

### Non-Network

20%

Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<p><b>27. Physician's Office Services</b> Covered Health Services received in a Physician's office including:</p>	<u>Network</u>	<u>Primary Care Physician</u>
<ul style="list-style-type: none"> <li>• Diagnosis and treatment of a Sickness or Injury.</li> <li>• Allergists', Dermatologists', and Podiatrists' office visits are covered.</li> <li>• Pain Management (Copayment does not apply if a Physician's office visit is not assessed).</li> <li>• Surgery in the Physician's office.</li> </ul>	<p>\$15 per visit (includes internal medicine, family practice, pediatrics and geriatrics)</p>	Yes
<p>Hospital based clinic visits are considered office visits and are subject to the office visit copayment listed.</p>	<u>Specialist</u>	\$25 per visit
<p>See Section 17 for information related to coverage of injections received in a Physician's office.</p>	No Copayment applies for flu shots.	
<p><b>Cancer treatment in a Physician's office or a Hospital based clinic</b></p>	<u>Non-Network</u>	20%
<p>Chemotherapy: This plan covers injectable anti-neoplastic prescription drugs when they are approved by us and are used solely for the purpose of cancer treatment. This plan covers physician services for administration of chemotherapy.</p>	<u>Network</u>	<p>\$25 per visit No Copayment applies when no Physician charge and/or clinic charge is assessed.</p>
		Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
Radiation Therapy: This plan covers physician services for radiation therapy received in a physician's office. Radiation physics, dosimetry services, treatment devices, and hospital services are included in radiation treatment planning and therapy and are covered as part of our allowance for radiation therapy.	<u>Non-Network</u>	20% Yes
<b>28. Podiatry Services</b>		
This plan covers office visits to the Podiatrist. The treatment of corns, or calluses, bunions (except capsular or bone surgery), the cutting and trimming of toenails, foot care for flat feet, fallen arches and chronic foot strain or symptomatic foot complaints (except when surgery is performed), and routine foot care are not covered.	<u>Network</u>	\$25 per visit Yes
Routine foot care including cutting of corns and calluses and trimming of nails, and debridement of nails are covered for severe systemic disease or preventive foot care for Covered Persons with diabetes.	<u>Non-Network</u>	20% Yes
<b>29. Preventive Care Services</b>		
<b>Covered Health Services for preventive medical care.</b>	<u>Network</u>	No Copayment No
Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under	<u>Non-Network</u>	20% Yes

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applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- Lyme Disease immunizations (covered for individuals aged 15-70 who live, work, or recreate in areas of high or moderate risk or whose exposure to tick-infested habitat is frequent or prolonged.)
- Breast Pumps.

Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<p>The purchase of a personal use double electrical breast pump will be covered 30 days prior to, or after, delivery.</p> <p>Network benefits are only available if breast pumps are obtained from an approved breast pump Network Physician. For a list of approved breast pump providers, please refer to <a href="http://www.myuhc.com">www.myuhc.com</a> or contact <i>Customer Care</i> at the telephone number shown on your ID card.</p>		
<p><b>30. Professional Fees for Surgical and Medical Services</b></p> <p>Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.</p> <p>This Plan covers physicians' visits in your home only if you have a condition resulting from an injury and illness which confines you to your home, requires special transportation or requires the assistance of another person.</p> <p>Surgery is only covered if the physician is licensed to perform the surgery. If a surgery is performed to diagnose an illness or condition, this Plan covers it. This Plan does not cover the diagnostic surgery if it is immediately followed by related surgery to treat that condition.</p> <p>If you are admitted to a General Hospital as an inpatient, this Plan</p>	<p><u>Network</u></p> <p>No Copayment</p> <p><u>House Calls</u> \$15 per visit By Primary Care Physician</p> <p>\$25 per visit by Specialist</p> <p><u>Non-Network</u></p> <p>20%</p>	<p>Yes</p> <p>Yes</p>

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covers the services of a physician in charge of your care, up to one (1) visit per day. Other physician visits are limited to one visit per day per specialty.

Kidney, cornea, and allogenic bone marrow transplants are considered general surgery procedures for the purposes of this plan. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.

In addition to the type and purpose of surgery, your coverage differs depending on the number of surgeons involved. If two (2) surgeons perform separate operations during a single surgical session, each surgeon may submit a claim reporting the procedure performed and the circumstances involved. These claims will then be evaluated for payment on an individual basis.

This Plan does NOT cover the services of an assistant surgeon for all surgeries. If we determine that it is medically necessary to use the services of an assistant surgeon during an operation, these services are covered only if he or she is a private practice Physician, not a Hospital employee. Your surgeon can not be paid as both the surgeon and assisting surgeon during the same surgical session.

This Plan does NOT cover the standby services of an assistant surgeon.

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

In addition to the type and purpose of surgery, your coverage

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differs depending on the number of surgeons involved. If two (2) surgeons perform separate operations during a single surgical session, each surgeon may submit a claim reporting the procedure performed and the circumstances involved. These claims will then be evaluated for payment on an individual basis.

This Plan does NOT cover the services of an assistant surgeon for all surgeries. If we determine that it is medically necessary to use the services of an assistant surgeon during an operation, these services are covered only if he or she is a private practice Physician, not a Hospital employee. Your surgeon can not be paid as both the surgeon and assisting surgeon during the same surgical session.

This Plan does NOT cover the standby services of an assistant surgeon.

If, while you are in the hospital, the attending physician in charge of your care requests the assistance of a physician who has special skills and knowledge to diagnose your condition, this Plan covers one specialist visit/one consultation per specialty per period of hospitalization. The transferring of a patient from one physician to another is not considered to be a consultation. A specialized physician who then treats you as his/her patient is not considered to be a consultant. Note that this Plan does NOT cover pathology consultations, telephone consultations or follow-up consultations.

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Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	
<p><b>31. Prosthetic Devices</b></p> <p>The following prosthetic devices that replace a limb or an external body part, including the replacement, repair or adjustment of these appliances (replacements will be allowed only if there is a change in your medical condition). Benefit includes the purchase of the devices and accessories and/or supplies necessary for attachment to an operation of prosthetic devices.</p> <ul style="list-style-type: none"> <li>• Artificial arms, legs, feet and hands.</li> <li>• Artificial eyes, ears and noses.</li> <li>• Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm</li> <li>• Prosthetic devices which replace or substitute all or a part of an internal body part (including contiguous tissue), or replace all or part of the function of a permanently inoperative or malfunctioning body part necessary to alleviate an illness, injury or congenital defect.</li> </ul>	<u>Network</u>	<u>Inpatient</u> No Copayment	No
<p>If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.</p> <p>The prosthetic device must be ordered or provided by, or under the direction of a Physician, except for items required by the Women's Health and Cancer Rights Act of 1998.</p>	<u>Non-Network</u>	<u>Inpatient</u> 20%	Yes
		<u>Outpatient</u> 20%	Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<p><b>32. Reconstructive Procedures/ Mastectomy Services</b></p> <p>Services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function.</p> <p>Cosmetic Services are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.</p> <p>This Plan covers the following procedures to treat functional impairments, when medically necessary.</p> <ul style="list-style-type: none"> <li>• Reduction Mammoplasty;</li> <li>• Prophylactic Mastectomy;</li> <li>• Removal of Breast Implants;</li> </ul>	<u>Network</u>	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.
	<u>Non-Network</u>	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.

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- Blepharoplasty;
- Ptosis Repair;
- Panniculectomy;
- Abdominoplasty;
- Repair of Pectus Excavatum;
- Septorhinoplasty;
- Nasal Reconstruction;
- Removal/Treatment of Symptomatic Benign Skin Lesions;
- Removal/Treatment of Proliferative Vascular Lesions and Hemangiomas;
- Treatment of Varicose Vein; and
- Orthognathic surgery including Mandibular and Maxillary Osteotomy.

Determinations for coverage of the above procedures may require review of medical documentation including history and physical, preoperative diagnostic studies, previously attempted conservative medical therapy and photographs or other medical records.

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 required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any

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other Covered Health Service.

Following a mastectomy, coverage includes a minimum of 48 hours in a Hospital and a minimum of 24 hours in a Hospital following an auxiliary node dissection. Any decision to shorten these minimum coverage's shall be made by the attending Physician in consultation with and upon agreement with the patient. If the patient participates in an early discharge, defined as inpatient care following a mastectomy that is less than 48 hours and inpatient care following auxiliary node dissection that is less than 24 hours, coverage shall include a minimum of 1 home visit conducted by a Physician or registered nurse. You can contact the Claims Administrator at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

**Notify Care Coordination**

Please remember that it is recommended to notify Care Coordination five business days before receiving services. When you provide notification, Care Coordination can verify that the service is a reconstructive procedure rather than a Cosmetic Procedure. Cosmetic Procedures are always excluded from coverage.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<h3>33. Rehabilitation Services - Outpatient Therapy</h3>	<u>Network</u>	Yes
<p>Short-term outpatient rehabilitation services for:</p> <ul style="list-style-type: none"> <li>Physical and Occupational therapy.</li> <li>Speech therapy.</li> <li>Post-cochlear implant aural therapy.</li> <li>Physical and/or occupational therapy is covered only when a program is implemented to restore the highest level of independent functioning in the most timely manner possible AND: <ul style="list-style-type: none"> <li>we determine that the therapy will result in significant, sustained, measurable functional/anatomical improvement of your condition; AND</li> <li>such improvement will not diminish with the removal of the therapeutic agent or environment.</li> </ul> </li> </ul>	<p>No Copayment applies for Physical or Occupational therapy within 30 days following a related Hospital stay, home care program, or ambulatory surgical procedure, otherwise 20%.</p> <p>20% applies to Speech therapy outpatient or physician's office</p>	<p>Yes, if therapy is within 30 days following a related hospital stay, home care program or ambulatory</p>
<p>Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician.</p>	<u>Non-Network</u>	20%

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum? surgical procedure, otherwise No.	
Neuro-Rehabilitation Day Treatment Program	<u>Network</u>	20%	Yes
	<u>Non-Network</u>	20%	Yes
<b>34. Rehabilitation Services – Cardiac Therapy</b>	<u>Outpatient Network</u>	20%	Yes
This Plan covers visits in a cardiac rehabilitation <u>program</u> , if the physician and facility are specifically accredited to perform cardiac rehabilitation and the following conditions are met:			
<ul style="list-style-type: none"> <li>• Acute myocardial infarction within the previous twelve (12) months from the start of cardiac rehabilitation.</li> <li>• Following coronary artery bypass graft surgery within the preceding twelve (12) months. Cardiac rehabilitation must begin within six (6) months of the coronary artery bypass graft surgery.</li> <li>• Following percutaneous transluminal coronary angioplasty.</li> <li>• Following valve replacements or repairs.</li> </ul>	<u>Outpatient Non-Network</u>	20%	Yes

Description of Covered Health Service	<u>Inpatient Network</u>	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<ul style="list-style-type: none"> <li>Stable angina pectoris: all patients must have had a pre-entry stress test that is positive for exercise induced ischemia within six (6) months of starting cardiac rehabilitation. The positive stress test should include perfusion studies demonstrating the ischemia.</li> <li>Compensated heart failure.</li> <li>Post-heart transplantation.</li> </ul>	<u>Inpatient Network</u>	No Copayment	No
<p>Outpatient cardiac rehabilitation therapy limited to 3 visits per week up to 12 weeks combined Network and Non-Network benefits. If received on an inpatient basis, Cardiac rehabilitation therapy is limited to 12 weeks or 36 visits, whichever comes first (and includes combined Network and Non-Network benefits).</p>	<u>Inpatient Non-Network</u>	20%	Yes
<h3>35. Respiratory Therapy – Outpatient/In a Physician’s Office</h3>	<u>Network</u>	No Copayment	No
<p>This Plan covers short-term outpatient respiratory therapy or respiratory therapy received in a Physician’s office when your Physician orders the therapy under the following conditions:</p>	<u>Non-Network</u>	20%	Yes
<ul style="list-style-type: none"> <li>(a) As part of a therapeutic program for up to fourteen (14) days before admitting you to the Hospital; OR</li> <li>(b) Up to six (6) weeks after you have been discharged from the Hospital.</li> </ul>			
<p>This plan does NOT cover respiratory therapy services when received in your home unless received through a pre-authorized</p>			

**Description of  
Covered Health Service**

**Your Copayment  
Amount**  
% Copayments are  
based on a percent of  
Eligible Expenses

**Does  
Copayment  
Help Meet  
Out-of-Pocket  
Maximum?**

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home care program or hospice care program.

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Description of Covered Health Service		Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<b>36. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</b>	<u>Network</u>	No Copayment	No
Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:			
<ul style="list-style-type: none"> <li>• Services and supplies received during the Inpatient Stay.</li> <li>• Room and board in a Semi-private Room (a room with two or more beds).</li> </ul>			
Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital.	<u>Non-Network</u>	20%	Yes
Preauthorization is recommended.			
<b>37. Smoking Cessation</b>	<u>Network</u>	No copayment	No
Tobacco cessation programs.			
Includes an annual outpatient benefit of eight (8) one half (1/2) hour smoking cessation counseling sessions provided by a qualified practitioner for each covered individual.	<u>Non-Network</u>	20% applies to outpatient counseling sessions. Appropriate prescription copayments apply.	Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<b>38. Speech Therapy - Outpatient/In a Physician's Office</b>	<u>Network</u>	20%
<p>This plan covers short-term outpatient speech therapy services or speech therapy services received in a registered therapist's office only when the speech impediment or speech dysfunction results from Injury, stroke, or a Congenital Anomaly and therapy is received from a registered therapist as part of a formal treatment plan.</p>		Yes
<p>This plan does NOT cover these services if such services are or would have been provided under state or federal laws which provide service for the health of school children or handicapped children (see generally, Title 16, Chapters 21, 24, 25 and 26 of the R. I. Gen. Laws and applicable regulations governing health of school children and the special education of handicapped children or comparable requirements established by federal law.)</p>	<u>Non-Network</u>	20%
<p>This plan does NOT cover speech therapy services received in your home unless it is part of an approved home care program.</p>		Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	
<p><b>39. Transplantation Services</b></p> <p>Covered Health Services for the following organ and tissue transplants when ordered by a Physician. Transplantation services must be received at a Designated Facility for Network benefits. Benefits are available for the transplants listed below when the transplant meets the definition of a Covered Health Service, and is not an Experimental, Investigational or Unproven Service:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Autologous bone marrow transplantation (in which the patient is his or her own donor) with high dose chemotherapy or radiation is only covered for the following conditions: <ul style="list-style-type: none"> <li>(a) State III or IV Hodgkin’s disease which has recurred after an initial complete remission with no bone marrow involvement;</li> <li>(b) State III or IV Intermediate or high grade non-Hodgkin’s lymphoma which has recurred after an initial complete remission with no bone marrow involvement;</li> <li>(c) State III or IV Neuroblastoma without bone marrow involvement; AND</li> </ul> </li> </ul> <p>To the extent that coverage for autologous bone marrow transplantation, as set forth in subsections (a) through (d) above, is more limited than the coverage required to be covered for “New</p>	<p><u>Designated Facilities</u></p>	<p>No Copayment</p>	<p>No</p>
<ul style="list-style-type: none"> <li>• Autologous bone marrow transplantation (in which the patient is his or her own donor) with high dose chemotherapy or radiation is only covered for the following conditions: <ul style="list-style-type: none"> <li>(a) State III or IV Hodgkin’s disease which has recurred after an initial complete remission with no bone marrow involvement;</li> <li>(b) State III or IV Intermediate or high grade non-Hodgkin’s lymphoma which has recurred after an initial complete remission with no bone marrow involvement;</li> <li>(c) State III or IV Neuroblastoma without bone marrow involvement; AND</li> </ul> </li> </ul>	<p><u>Non-Network</u></p>	<p>50% Benefits are limited to \$30,000 per transplant</p>	<p>Yes</p>

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<p>Cancer Therapies,” the applicable provisions of the Rhode Island General Laws shall govern. (See Section 2: Cancer Therapies – Investigational.)</p> <p><b>Related Exclusion</b></p> <p>This plan does NOT cover autologous bone marrow transplantation (with high dose chemotherapy and/or radiation) except as provided in this section and Section 2: Cancer Therapies – Investigational. This exclusion pertains to, but is not limited to, the following treatments:</p> <ul style="list-style-type: none"> <li>• Acute leukemia in first remission;</li> <li>• Hodgkin’s or non-Hodgkin’s lymphoma in first remission;</li> <li>• Breast cancer;</li> <li>• Intrinsic brain tumors;</li> <li>• Ovarian cancer;</li> <li>• Lung cancer;</li> <li>• Testicular cancer;</li> <li>• Colon cancer;</li> <li>• Wilm’s tumor; AND</li> <li>• Acquired immunodeficiency syndrome and human immunovirus infection.</li> <li>• Allogenic Bone Marrow Transplants are covered. This includes medical and surgical services for the matching participant donor</li> </ul>		

**Description of  
Covered Health Service**

**Your Copayment  
Amount**  
% Copayments are  
based on a percent of  
Eligible Expenses

**Does  
Copayment  
Help Meet  
Out-of-Pocket  
Maximum?**

and the recipient. Costs associated with donor searches are covered up to a maximum of \$25,000 only if the transplant is performed at a Designated Facility. Costs associated with donor searches are not covered if the transplant is not performed at a Designated Facility.

- Benefits are available for one human leukocyte antigen testing per lifetime or histocompatibility locus antigen testing that is necessary to establish bone marrow transplant donor suitability, including testing for A, B or DR antigens, or any combination of those tests. The testing must be performed in a facility which is:
  - (a) accredited by the American Association of Blood Banks or its successors; and
  - (b) licensed under the Clinical Laboratory Improvement Act as it may be amended from time to time.

At the time of testing, the person being tested must complete and sign an informed consent form which also authorizes the results of the test to be used for participation in the National Marrow Donor program.

- Heart transplants.
- Heart/lung transplants.
- Lung transplants.
- Kidney transplants.
- Kidney/pancreas transplants.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	
<ul style="list-style-type: none"> <li>• Liver transplants.</li> <li>• Liver/kidney transplants.</li> <li>• Liver/small bowel transplants.</li> <li>• Pancreas transplants.</li> <li>• Small bowel transplants.</li> </ul>			
<p>Covered Hospital Services for transplants include: obtaining donated organs (including removal from a cadaver), donor medical and surgical expenses related to obtaining the organ, and transportation of the organ from donor to recipient.</p>			
<p>The transplant benefit period begins five days before a covered organ transplant and continues through one year afterwards. During a benefit period, this plan covers the following services:</p>	<u><b>Network</b></u>	<p><u><b>Human Leukocyte Antigen Testing</b></u> No Copayment</p>	No
<ul style="list-style-type: none"> <li>(a) covered hospital expenses;</li> <li>(b) the physician's fee you are charged for surgical, medical and other services related to a covered organ transplant when these services are performed, ordered or supervised by a physician.</li> <li>(c) additional transplant charges for medically necessary services and supplies during a transplant benefit period if they are not covered under this plan. They must be performed, ordered and/or supervised by a physician.</li> </ul>			
<p>Network Benefits are available for cornea, kidney, allogenic bone marrow transplants and Human Leukocyte Antigen Testing that are provided by a Network Physician at a Network Hospital. We do not</p>	<u><b>Non-Network</b></u>	20%	Yes

**Description of  
Covered Health Service**

**Your Copayment  
Amount**

% Copayments are  
based on a percent of  
Eligible Expenses

**Does  
Copayment  
Help Meet  
Out-of-Pocket  
Maximum?**

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require that cornea, kidney, allogenic bone marrow transplants or Human Leukocyte Antigen Testing be performed at a Designated Facility in order for you to receive Network Benefits. For cornea transplants, Benefits will be paid at the same level as *Professional Fees for Surgical and Medical Services, Outpatient Surgery, Diagnostic and Therapeutic Services, and Hospital - Inpatient Stay* rather than as described in this section "*Transplantation Services*".

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

**Transportation and Lodging**

The services described under **Transportation and Lodging** below are Covered Health Services **ONLY** in connection with a transplant received at a Designated Facility.

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

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
- Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Designated Facility.

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<p>There is a combined overall maximum Benefit of \$5,000 per Covered Person per Transplant for all transportation and lodging expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures.</p>		
<p><b>40. Urgent Care Center Services</b></p>		
<p>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 <i>Physician's Office Services</i> earlier in this section.</p>	<u>Network</u>	\$50 per visit Yes
<p>No copayment applies for a flu shot in network. A 20% copayment is assessed out of network.</p>	<u>Non-Network</u>	20% Yes

Description of Covered Health Service	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?
<p><b>41. Wigs (Effective 01/01/07)</b></p> <p>Coverage for scalp hair prosthesis worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia, provided, however, that such coverage shall be subject to the same limitations and guidelines as other prosthesis, and that coverage shall not exceed an amount of three hundred fifty dollars (\$350) per covered member per year, exclusive of any deductible.</p>	<u>Network</u>	20% Yes
<p>A prescription from a Physician is required and a wig must be purchased from a Durable Medical Equipment Provider.</p>	<u>Non-Network</u>	20% Yes

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

This section contains information about:

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

### How We Use Headings in this Section

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

### We Do not Pay Benefits for Exclusions

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

- It is recommended or prescribed by a Physician.

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- It is the only available treatment for your condition.

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

### A. Alternative Treatments

1. Acupressure, acupuncture and all services performed by an Acupuncturist.
2. Aroma therapy.
3. Hypnotism.
4. Massage Therapy.
5. Rolfing.
6. Recreational Therapy.
7. Pet Therapy.
8. Aqua Therapy.
9. Maintenance Therapy.
10. Pelvic floor electrical stimulation, biofeed training, pelvic floor exercises, and any other exercise therapy.
11. Biofeedback by any modality.
12. Therapies, procedures, and services for purposes of relieving stress.
13. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

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## B. Comfort or Convenience

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

## 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.

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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.
7. This Plan does not cover general dental services such as extraction (including full mouth extractions), prostheses, braces, operative restorations, fillings, medical or surgical treatments or dental caries, gingivitis, impactions, periodontal surgery, non-surgical treatment of TMJ, including appliances or restorations necessary to increase vertical dimensions or to restore the occlusion, anesthesia administered in a dentist's office, anorexia x-rays or dental x-rays.
8. This Plan does not cover dental appliances or devices.
9. This Plan does not cover injuries incurred as a result of biting/chewing.
10. This Plan does not cover any preparation of the mouth for dentures and/or dental or oral surgeries such as but not limited to:
  - Apicoectomy, per tooth, first root;
  - Removal of partially bony impacted tooth;
  - Surgical removal of partial bony impaction;
  - Removal of completely bony impacted tooth, with or without unusual surgical complications;
  - Surgical removal of residual tooth roots;

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- Vestibuloplasty with skin mucosal graft and lowering the floor of the mouth;
- Complete surgical removal of inaccessible impacted mandibular tooth mesial surface;
- Surgical removal of impacted maxillary tooth;
- Operculectomy excision pericoronal tissues;
- Excision of feberous tuberosities;
- Excision of hyperplastic alveolar mucosa, each quadrant;
- Alveolectomy including curettage of osteitis or sequestrectomy; and
- Alceoplasty, each quadrant.

## D. Drugs

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

## E. Experimental, Investigational or Unproven Services

Experimental, Investigational and Unproven Services are excluded except as described in (Section 1: What's Covered--Benefits) under the heading *Cancer Therapies - Investigational and Lyme Disease*. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the

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

procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 1, *What's Covered – Benefits*.

We have the right and discretionary authority to determine whether a service is experimental/investigational, and any such determination made by us in good faith is binding on you.

## F. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
  - Elastic stockings.
  - Ace bandages.
  - Gauze and dressings.
  - Alcohol swabs.
3. Corrective shoes and orthotic devices used in connection with footwear.
4. Tubings and masks are not covered except when used with Durable Medical Equipment as described in (Section 1: What's Covered—Benefits).
5. Pillows supplied by a Chiropractic Physician.

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## G. Mental Health/Substance Use Disorder

Exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders* and/or *Substance Use Disorder Services* as described in (Section 1: What’s Covered – Benefits).

1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
2. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or Substance Use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:
  - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
  - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
  - Not consistent with the Mental Health/Substance Use Disorder Administrator’s level of care guidelines or best practices as modified from time to time.
  - Not clinically appropriate for the patient’s Mental Illness, Substance Use disorder or condition based on generally accepted standards of medical practice and benchmarks.
3. Substance Use Disorder treatment services received in your home.
4. Recreation therapy, non-medical self-care, or self-help training.

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5. Services performed at Substance Use Disorder facilities that are not approved and licensed by the state.
6. Mental, family or other counseling or training services unless the member is diagnosed with a mental disorder.
7. Mental Health Services as treatments for V-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
8. Mental Health Services as treatment for a primary diagnosis of insomnia or other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.
9. Treatments for the primary diagnosis of learning disabilities, conduct and impulse control disorders, personality disorder, paraphilias, (sexual behavior that is considered deviant or abnormal) and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as determined by the MG / SUD Administrator.
10. Educational / behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
11. Tuition for or services that are school – based for children and adolescents under the *Individuals with Disabilities Act*.
12. Learning, motor skills and primary communication disorders as defined in the current edition of *the Diagnostic and Statistical Manual of the American Psychiatric Association*.
13. Mental Retardation as a primary diagnosis defined in the current edition of *the Diagnostic and Statistical Manual of the American Psychiatric Association*.

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14. Substance Use Disorder Services for the treatment of caffeine use.
15. Pastoral counseling.
17. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

## H. Nutrition

1. Megavitamin and nutrition based therapy.
2. Nutritional counseling for either individuals or groups except as specifically described in (Section 1: What's Covered—Benefits).
3. Nutritional and electrolyte supplements, including infant formula and donor breast milk.

## I. 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;
  - Correction of variations in normal anatomy including augmentation mammoplasty and correction of congenital breast symmetry;
  - Rhinoplasty;

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- Rhytidectomy;
- Genioplasty;
- Otoplasty;
- Cervicoplasty;
- Osteoplasty: Facial Bone Reduction;
- Scar Revision;
- Excision of Excess Skin or Subcutaneous Tissue;
- Subcutaneous Injection of Filling Material;
- Removal of Asymptomatic Benign Skin Lesions;
- Dermabrasion
- Chemical Peel;
- Chemical Exfoliation for Acne;
- Suction assisted Lipectomy as Primary Procedure;
- Hair Transplants;
- Electrolysis Epilation;
- Procedures to correct visual acuity including, but not limited to, Radial Keratotomy;
- Ear Piercing; and
- Sclerotherapy for Spider Veins.

Medically necessary surgery performed at the same time as a cosmetic procedure is NOT covered. (For example, septoplasty or submucous resection performed in connection with rhinoplasty).

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2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.  
**Note:** Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 1: What's Covered--Benefits.
3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
4. Weight loss programs whether or not they are under medical supervision. This Plan does not cover health care services, including drugs, related to programs/procedures designed for the purpose of weight loss, such as, but not limited to, commercial diet plans, weight loss programs, and any services in connection with such plans or programs.

## J. Providers

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

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

This exclusion does not apply to mammography testing.

4. Services received in a facility primarily designed to care for students, faculty, or employees of a college or other institution of learning.
5. Services in convalescent homes, home for the aged, halfway houses or other residential facilities.
6. Services performed by a physician, surgeon, or other person who is not legally qualified or licensed according to relevant sections of RI General Laws or other governing bodies or who does not meet our credentialing requirement.
7. Services of Christian Science Practitioners.
8. Hemodialysis services received in a physician's office.
9. Extra charges for a private hospital room are not covered if a semi-private room is available.

## K. Reproduction

Services related to:

1. Surrogate parenting.
2. The reversal of voluntary sterilization (including any services for infertility related to voluntary sterilization or its reversal).
3. Health services and associated expenses for elective abortion.
4. Fetal reduction surgery.
5. Health services associated with the use of non-surgical or drug-induced Pregnancy termination.
6. Freezing and storage of gametes, sperm, embryos, and other specimen for future use.

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7. Genetic counseling and amniocenteses or any other service used to determine the sex of an infant before it is born.

## L. Services Provided under Another Plan/Available from Other Sources

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.

Health care services performed to treat work-related illnesses, conditions, or injuries, whether or not the member is covered by Workers' Compensation law, unless the member is self-employed or a member of a partnership and such work-related illness, conditions, or injuries were incurred in the course of the self-employment or partnership activities.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.
4. Services when the member can recover all or a portion of the cost of such services through a federal, state, county, or municipal law or through legal action. This is true even if the member chooses not to assert his/her rights under these laws

## M. Transplants

1. Health services for organ and tissue transplants, except those described in Section 1: What's Covered--Benefits.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor

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costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan).

3. Health services for transplants involving mechanical or animal organs.
4. Any solid organ transplant that is performed as a treatment for cancer.
5. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Health Services* in Section 1: What's Covered--Benefits.

## N. Travel

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

## O. Vision

1. Purchase cost of eye glasses or contact lenses.
2. Fitting charge for eye glasses or contact lenses.
3. Eye exercise therapy or visual training services.
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.
5. Routine vision examinations, including refractive examinations.

## P. Diagnostic Tests

This Plan does NOT cover the following x-rays:

- Perineograms;
- Xeroradiography;
- Myocardial imaging;

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- Positron emission tomography (PET);
- Fluoroscopic chest x-ray; and
- Any imaging for screening purposes (except for mammograms as described above).

This Plan does NOT cover the following tests:

- Bone marrow blood supply MRIs;
- Electrocardiograms to determine anesthesia risk; magnetic resonance angiography of the pelvis and/or upper or lower extremities;
- Transtelephonic EKGs; and
- Telephone pacemaker monitoring.

This plan does NOT cover lab tests for screening purposes (except Pap Smears, PSA and colorectal lab tests as described above).

This plan does NOT cover audiometric hearing or speech services if such services are or would have been provided under state or federal laws which provide service for the health of school children or handicapped children. (See generally, Title 16, Chapters 21, 24, 25, and 26 of the Rhode Island General Laws and applicable regulations governing the health of school children and the special education of handicapped children or comparable requirements established by federal law or state law of applicable jurisdiction.)

## 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.

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This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement.

2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
  - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
  - Related to judicial or administrative proceedings or orders.
  - Conducted for purposes of medical research.
  - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
4. Except as otherwise provided in “Section 8: When Coverage Ends”, health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
6. In the event that a non-Network provider waives Copayments for a particular health service, no Benefits are provided for the health service for which the Copayments are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Non-surgical services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered to be medical or dental in nature.

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- 9.. Surgical and Non-surgical treatment of obesity, including morbid obesity excluding those deemed to be medically necessary and are not experimental or unproven.
10. Private duty nursing provided on an inpatient and outpatient basis.
11. Growth hormone therapy.
12. Sex transformation operations and health care services related to sex transformations.
13. Custodial Care, day care, or non-skilled care.
14. Domiciliary care.
15. Respite care.
16. Rest cures.
17. Psychosurgery.
18. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
19. Oral appliances for snoring excluding those deemed by a Physician medically necessary as part of treatment for documented obstructive sleep apnea.
20. Except as otherwise provided in “Section 1: What’s Covered – Benefits”, speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly.
21. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
22. Any charge for services, supplies or equipment advertised by the provider as free.
23. Any charges prohibited by federal anti-kickback or self-referral statutes.
24. Repeated cauterizations or electrofulguration methods used to remove growths on the skin.
25. Fluoroscopy without films.
26. Psychoanalysis or psychotherapy services you receive which are credited towards a degree or to further your education or training regardless of symptoms that you may have.
27. Supervision of maintenance therapy for chronic disease which is aggravated by surgery and would not ordinarily require hospitalization.
28. Rehabilitation for maintenance purposes.
29. Procedures to determine post-operative fluid or electrolyte balance.
30. Gene therapy.
31. Any services related to drawing, processing or storage of your own blood.
32. Whole blood, red blood cells, blood replacement and penalty fees.
33. Charges for services and supplies required under the laws of a state other than the State of Rhode Island and which are not provided under this plan.
34. Services that may in and of themselves otherwise be covered, when provided attendant to a non-covered course of service or as a component of a non-covered regimen of care.
35. The following expenses related to receiving hemodialysis services in the home: installation or modification of electric power, water and sanitary disposal or changes for these services, moving expenses for relocating the machine, installation expenses not necessary to operate the machine or to train you or member of your family in the operation of the machine.
36. Thighplasty, brachioplasty and mastopexy.

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# Section 3: Description of Network and Non-Network Benefits

This section includes information about:

- Network Benefits.
- Non-Network Benefits.
- Your responsibility for notification.
- Emergency Health Services.

## Network Benefits

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

- Provided by a Network Physician, Network facility, or other Network provider.
- Emergency Health Services.

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## *Comparison of Network and Non-Network Benefits*

	Network	Non-Network
<b>Benefits</b>	A higher level of Benefits means less cost to you. See Section 1: What's Covered--Benefits.	A lower level of Benefits means more cost to you. See Section 1: What's Covered--Benefits.
<b>Who Should Notify the Claims Administrator for Personal Health Support</b>	See Section 1: Notification Requirements.	See Section 1: Notification Requirements.
<b>Who Should File Claims</b>	Not required. We pay Network providers.	You must file claims. See Section 5: How to File a Claim.
<b>Outpatient Emergency Health Services</b>	Emergency Health Services are always paid as a Network Benefit (paid the same whether you are in or out of the Network). That means that if you seek Emergency care at a non-Network facility, you are not required to pay any difference between Eligible Expenses and the amount the provider bills.	

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### ***Provider Network***

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

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

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

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

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

### ***Personal Health Support***

Your Network Physician is required to notify the Claims Administrator regarding certain proposed or scheduled health services. When your Network Physician notifies the Claims

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Administrator, they will work together to implement the Personal Health Support process and to provide you with information about additional services that are available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy.

If you receive certain Covered Health Services from a Network provider, you must notify the Claims Administrator. The Covered Health Services for which notification is required is shown in (Section 1: What's Covered--Benefits). When you notify the Claims Administrator, you will receive the Personal Health Support services described above.

### ***HealtheNotes<sup>SM</sup>***

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

The Claims Administrator makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine.

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

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

### ***Designated Facilities and Other Providers***

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

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

You or your Network Physician must notify the Claims Administrator of special service needs (including, but not limited to, transplants or cancer treatment) that might warrant referral to a Designated Facility or non-Network Facility or provider. If you do not notify the Claims Administrator in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Plan.

### ***Health Services from Non-Network Providers Paid as Network Benefits***

If specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify the Claims

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Administrator, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

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

If you don't make a selection within 31 days of the date we notify you, the Claims Administrator will select a single Network Physician for you.

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

## **Non-Network Benefits**

Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits are payable for Covered Health Services that are provided by non-Network providers.

Depending on the geographic area and the service you receive, you may have access to providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, and if your Copayment is expressed as a percentage of Eligible Expenses for Non-Network Benefits, that percentage will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from other non-Network providers, because the Eligible Expense may be a lesser amount.

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## Your Responsibility for Notification

See Pre-Authorization in Section 1.

### *Personal Health Support*

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

## Emergency Health Services

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

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

If you are confined in a non-Network Hospital after you receive Emergency Health Services, the Claims Administrator must be notified within 48 hours or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

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## Section 4: When Coverage Begins

This section includes information about:

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

### How to Enroll

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

### If You Are Hospitalized When Your Coverage Begins

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

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

- the date such confinement or treatment ends; or
- thirty (30) days from the date the facility or provider are no longer part of the Network.

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

### If You Are Eligible for Medicare

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

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

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## Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
<b>Eligible Person</b>	<p>Eligible Person usually refers to a retiree of ours who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Participant. For a complete definition of Eligible Person and Participant, see Section 10: Glossary of Defined Terms.</p> <p>Except as we have described in Section 4: When Coverage Begins, Eligible Persons may not enroll.</p>	<p>We determine who is eligible to enroll under the Plan.</p>
<b>Dependent</b>	<p>Dependent generally refers to the Participant's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see Section 10: Glossary of Defined Terms.</p> <p>Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan.</p> <p>Except as we have described in Section 4: When Coverage Begins, Dependents may not enroll.</p>	<p>We determine who qualifies as a Dependent.</p>

## When to Enroll and When Coverage Begins

When to Enroll	Who Can Enroll	Begin Date
<b>Initial Enrollment Period</b> The Initial Enrollment Period is the first period of time when Eligible Persons can enroll.	Eligible Persons may enroll themselves and their Dependents.	Coverage begins on the date identified by the Plan Administrator, if the Plan Administrator receives the completed enrollment form and any required contribution for coverage within 31 days of the date the Eligible Person becomes eligible to enroll.
<b>Open Enrollment Period</b>	Eligible Persons may enroll themselves and their Dependents.	The Plan Administrator determines the Open Enrollment Period. Coverage begins on the date identified by the Plan Administrator if the Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the date the Eligible Person becomes eligible to enroll.
<b>New Eligible Persons</b>	New Eligible Persons may enroll themselves and their Dependents.	Coverage begins on the date of hire if the Plan Administrator receives the properly completed enrollment form and any required contribution for coverage within 31 days of the date the new Eligible Person becomes eligible to enroll and if the Participant pays any required contribution to the Plan Administrator for Coverage.  If you or your dependents fail to enroll at this time, you cannot enroll in the Plan unless you do so through an Open Enrollment Period or a Special Enrollment Period.

## Adding New Dependents

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

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- Registering a Common Law Spouse.
- Registering a Domestic Partner.
- Civil Union.

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

## Special Enrollment Period

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

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

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

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

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

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

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

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

- Coverage under the prior plan ended because of any of the following:
  - Loss of eligibility (including, without limitation, legal separation, divorce, death, termination of employment, or a reduction in the number of hours of employment).
  - The employer stopped paying a contribution. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
  - In the case of COBRA continuation coverage, the coverage ended.
  - The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.
  - The Plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
  - Termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must notify the Plan Administrator within 60 days of termination).

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## Section 5: How to File a Claim

This section provides you with information about:

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

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

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

Network providers file claims for you and must do so within ninety (90) days of providing a covered service to you.

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### Filing a Claim for Benefits

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us through the Claims Administrator. You must file all claims within ninety (90) after receiving a covered service.

Failure to file the claim within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Participant, later than one (1) year from the time proof is otherwise required.

We will send you an Explanation of Benefits (EOB) whenever you have a coinsurance. Our payments to you or the provider fulfill our responsibility under this plan. Your benefits are personal to you and cannot be assigned, in whole or in part, to another person or organization.

If a retail or mail order pharmacy fails to fill a prescription that you have presented, you may contact the Claims Administrator by submitting a claim for coverage as set forth in the procedures for filing a pre-service health plan claim (described in this section).

#### ***Required Information***

Non-Network providers may or may not file claims for you. If the Non-Network provider does not file the claim on your behalf, you will need to file the claim yourself. To file a claim, please send us an itemized bill including the following information:

- A. Participant's name and address.
- B. The patient's name, age and relationship to the Participant.

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- C. The member number stated on your ID card.
- D. An itemized bill from your provider that includes the following:
  - Patient diagnosis
  - Date of service
  - Procedure code(s) and description of service(s) rendered
  - Provider of service (Name, Address and Tax Identification Number)
- E. The date the Injury or Sickness began.
- F. A statement indicating 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***

Benefits are paid within the time frames shown below after the Claims Administrator receives a request for payment that includes all required information.

- 30 days after receipt of a request submitted by electronic means.
- 40 days after receipt of a request submitted by other than electronic means.

Requests for payment that include all required information which are not paid within these time frames will include an overdue payment of interest at the rate of 12% per annum

### ***Benefit Determinations***

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

Post-Service Claims are those claims that are filed for payment of benefits after medical care has been received. If your post-service

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claim is denied, you and the provider will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30-day period if additional information is needed to process the claim.

Once all of the needed information is received, if the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received.

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

#### ***Pre-Service Requests for Benefits***

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

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### ***Urgent Requests for Benefits that Require Immediate Action***

Urgent requests for Benefits are those that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition could cause severe pain. In these situations:

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

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

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

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

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

In the event that prior authorization of services is not available for an emergency service, that service will be deemed covered.

### ***Concurrent Care Claims***

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. 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 request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

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## Section 6: Questions, Complaints, Adverse Benefit Determinations and Appeals

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

- You have a question or concern about Covered Health Services or your Benefits.
- You have a complaint.
- We notify you that we will not be paying a claim because we have determined that a service or supply is excluded under the Plan.

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

### What to Do if You Have a Question

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

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### What to Do if You Have a Complaint

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the *Customer Care* representative can provide you with the appropriate address.

If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

### Adverse Benefit Determinations

An adverse benefit determination is a decision made by us, in accordance with the terms of the Policy, to deny, reduce, terminate, or not pay for (in whole or in part) a benefit. Adverse benefit determinations include those based on your or your dependent's eligibility for coverage (for example, a rescission of coverage) as well as those based on Utilization Review.

Utilization Review means a review of the use and/or appropriateness of a health care service. This includes those services determined to be experimental or investigational.

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# How to Appeal an Adverse Benefit Determination

Your appeal of an adverse benefit determination will fall under one of the following categories:

## Post-service Claims

Post-service claims are those filed for payment of Benefits after medical care has been received.

## Post-service Requests for Benefits

Post-service requests for Benefits are requests for Benefits made after medical care has been received.

## Pre-service Requests for Benefits

Pre-service requests for Benefits are requests made for prior authorization or benefit confirmation prior to receiving medical care.

## Concurrent Requests for Benefits

Concurrent requests for Benefits are requests made for authorization during the time while medical care is currently being received.

## How to Request an Appeal

If you disagree with an adverse benefit determination made on a post-service claim, post-service request, pre-service request or concurrent request, you, your authorized representative, or your provider, must request an appeal in writing and send:

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United HealthCare Services, Inc.  
P. O. Box 30573  
Salt Lake City, Utah 84130-0573

Your request for an appeal should include:

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

Your first appeal must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial. Information about this process will be included in the Explanation of Benefits, Health Statement, and/or the final determination letter sent from us.

You may also follow this process to appeal an adverse benefit determination based on rescission of coverage.

For procedures associated with urgent requests for Benefits, see Expedited Review of Urgent Appeals below.

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## Appeals Process

A qualified individual who was not involved in the initial decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and to the sharing of pertinent medical claim information. We will not make an adverse benefit determination until an appropriately qualified licensed practitioner has spoken with, or attempted to speak with, your attending or ordering physician. We will make no less than the minimum number of documented attempts required by state law to reach your attending physician before reaching a determination.

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 or request for Benefits, including copies of any internal rule, guideline or protocol that we may rely on in reaching a determination. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

If you are appealing an adverse benefit determination of a concurrent request for Benefits, coverage will be continued without financial liability beyond the applicable cost share until you are notified of the appeal determination.

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## Appeals Determinations

There are two levels of appeals for adverse benefit determinations. You will be provided written or electronic notification of the decision on your appeal as follows:

- Pre-service, concurrent, or post-service requests, or post-service claims – clinical matters:

A first level appeal review will be conducted. You will be notified of the first level appeal decision within 15 days from receipt of a request with all the necessary information.

If you are not satisfied with this decision, you can request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. You will be notified of the second level appeal decision within 15 days from receipt of a request with all the necessary information.

- Post-service claims - non-clinical matters

A first level appeal review will be conducted. You will be notified of the first level appeal decision within 30 days from receipt of a request with all the necessary information.

If you are not satisfied with this decision, you can request a second level appeal. Your second level appeal request must be submitted to us within 60 days from your receipt of the first level appeal decision. You will be notified of the second level appeal within 15 days from receipt of a request with all the necessary information.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure or service rendered. We don't decide whether the pending health service is necessary or appropriate. That decision is between you and your Physician.

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You have the right to external review through an Independent Review Organization (IRO) upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

## Expedited Review of Urgent Appeals

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 situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- Taking into account the seriousness of your condition, we will provide you with a determination as soon as possible. In no event will the determination be provided later than 72 hours after receipt of your request with all the necessary information for review of the appeal.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

## External Review

After you complete the internal appeal process, if you remain dissatisfied with our final appeal determination, you may request an external review through an outside Independent Review Organization (IRO). We will bear the cost of the external review although you may be responsible for a filing fee of up to \$25 per

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claim, not to exceed \$75 in a given plan year. There is no minimum dollar amount that a claim must be in order to file an external appeal.

The external appeal is voluntary. An external review is comprised of all of the following:

- A preliminary review by us of the request.
- A referral of the request by us to the IRO.
- A decision by the IRO.

To request an external review within four (4) months of your receipt of our second level appeal review determination, you must submit your request in writing to:

United HealthCare Services, Inc.  
P. O. Box 30573  
Salt Lake City, Utah 84130-0573

A request for an external review of an urgent appeal may be made verbally. We will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Policy at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.
- Has provided all the information and forms required so that we may process the request.

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After we complete the preliminary review, if your request is eligible for external review, we will forward your request to the *IRO* within five (5) business days for non-urgent appeals, or two (2) business days for an urgent appeal. We will provide to the assigned *IRO* the documents and information considered in making our determination. The documents include:

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

The *IRO* will notify you of its determination within ten (10) days for non-urgent appeals, or two (2) days for urgent appeals, after it receives this information. The determination of the *IRO* is binding upon us.

You may contact us at the toll-free number on your ID card for more information regarding external review rights.

## **Limitation of Action**

After an adverse benefit determination has been rendered, you cannot bring any legal action against us to recover reimbursement without first fully exhausting the internal and external appeals procedures provided in this section. Any such failure to exhaust these administrative remedies prior to bringing suit may result in a judicial dismissal of your case.

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## **Grievances Unrelated to Claims**

We encourage you to discuss any complaint that you may have about any aspect of your medical treatment with the health care provider that furnished the care. In most cases, issues can be more easily resolved when they are raised when they occur. If however, you remain dissatisfied or prefer not to take up the issue with your provider, you may access the complaint and grievance procedures.

You may access the complaint and grievance procedures if you have a complaint about the service or regarding one of the employees of the Claims Administrator. In order to initiate a grievance, please call the Customer Service Department at the number on the back of your ID card. The Customer Service Department will log in your call and begin working towards the resolution of your complaint.

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## Section 7: Coordination of Benefits

This section provides you with information about:

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

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

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

### When Coordination of Benefits Applies

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

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

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

### Definitions

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

1. "Coverage Plan" is any of the following that provides benefits or services for medical 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: (1) Group insurance or group-type coverage whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage. (2) Coverage under a governmental plan, or coverage required to be provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).
  - 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

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or there is no semi private room available) is not an Allowable Expense.

- b. If a person is covered by two or more Coverage Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.
  - c. If a person is covered by two or more Coverage Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
  - d. If a person is covered by one Coverage Plan that calculates its benefits or services on the basis of usual and customary fees and another Coverage Plan that provides its benefits or services on the basis of negotiated fees, the Primary Coverage Plan's payment arrangements shall be the Allowable Expense for all Coverage Plans.
  - e. The amount a benefit is reduced by the Primary Coverage Plan because a Covered Person does not comply with the Coverage Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.
4. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.
  5. "Closed Panel Plan" is a Coverage Plan that provides health benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

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6. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

## Order of Benefit Determination Rules

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

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

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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.

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

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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.
- 3. Active or inactive employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled D.1.
- 4. Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored.
- 5. Longer or shorter length of coverage. The Coverage Plan that covered the person as an employee, member, subscriber or retiree longer is primary.

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- 6. If a husband or wife is covered under this Coverage Plan as a Participant and as an Enrolled Dependent, the dependent benefits will be coordinated as if they were provided under another Coverage Plan, this means the Participant's benefit will pay first.
- 7. If the preceding rules do not determine the Primary Coverage Plan, the Allowable Expenses shall be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this provision. In addition, this Coverage Plan will not pay more than it would have paid had it been primary.
- E. A group or individual automobile contract that provides medical, no-fault or personal injury protection benefits or a homeowner's policy that provides medical benefits coverage shall provide primary coverage.

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

- A. When this Coverage Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Coverage Plans during a claim determination period are not more than 100 percent of total Allowable Expenses.
  - 1. Determine its obligation to pay or provide benefits under its contract;
  - 3. Determine whether there are any unpaid Allowable Expenses during that claim determination period.
- B. If a Covered Person is enrolled in two or more closed panel Coverage Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel Coverage Plan, COB shall not apply between that Coverage Plan and other closed panel Coverage Plans.

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

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

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

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

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

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

## **Payments Made**

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

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## Right of Recovery

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

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## Section 8: When Coverage Ends

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

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

### 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, unless you are totally disabled and we 1) cease to offer medical coverage to our employees or 2) replace our self insured plan with a fully insured plan. (See “Continuation of Coverage and Conversion” in this section for limited circumstances providing continuation of coverage – page 98.)

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

An Enrolled Dependent's coverage ends on the date the Participant's coverage ends unless otherwise specifically provided herein.

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## Events Ending Your Coverage

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

Ending Event	What Happens
<b>The Entire Plan Ends</b>	Your coverage ends on the date the Plan ends. We are responsible for notifying you that your coverage has ended.
<b>You Are No Longer Eligible</b>	Your coverage ends on the date you are no longer eligible to be a Participant or Enrolled Dependent. Please refer to Section 10: Glossary of Defined Terms for a more complete definition of the terms "Eligible Person", "Participant", "Dependent" and "Enrolled Dependent". (You will not become ineligible due to an adverse change in your health or the health status of any dependent.)
<b>The Claims Administrator Receives Notice to End Coverage</b>	Your coverage ends on the date the Claims Administrator receives written notice from us instructing the Claims Administrator to end your coverage, or the date requested in the notice, if later.
<b>Participant Retires or Is Pensioned</b>	Your coverage ends the date the Participant is retired or pensioned under the Plan. We are responsible for providing written notice to the Claims Administrator to end your coverage.  This provision applies unless we designate a specific coverage classification for retired or pensioned persons, and only if the Participant continues to meet any applicable eligibility requirements. We can provide you with specific information about what coverage is available for retirees.
<b>Notification to Us</b>	It is your obligation to promptly notify us of any event outlined herein that would be cause for coverage for you and/or your dependents to end (ex. Marriage of a child, death, loss of eligibility, attainment of a certain age, change in student status, divorce, legal separation or annulment, etc.).

## Other Events Ending Your Coverage

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

Ending Event	What Happens
<b>Fraud, Misrepresentation or False Information – Re: Eligibility for Coverage</b>	The Participant commits an act, practice, or omission that constituted fraud or an intentional misrepresentation of a material fact. Examples include, but are not limited to, false information relating to another person's eligibility or status as a Dependent. We have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.
<b>Material Violation</b>	There was a material violation of the terms of the Plan.
<b>Improper Use of ID Card</b>	You permitted an unauthorized person to use your ID card, or you used another person's card.
<b>Failure to Pay</b>	Your coverage ends on the date identified by the Plan sponsor if you failed to pay a required contribution.
<b>Threatening Behavior</b>	You committed an act of physical or verbal abuse that imposes a threat to our staff, the Claims Administrator's staff, a provider, or other Covered Persons.

## Coverage for a Handicapped Child

If you have an unmarried child of any age who is medically certified as disabled and is chiefly dependent on you for support and care because of a mental impairment or physical disability which can be expected to result in death or can be expected to last for a continuous period of not less than 12 months, that child may be an eligible Enrolled Dependent under the terms of the Policy.

If you have a child that you believe is a Disabled Dependent, you will need to furnish us with proof of the medical certification of disability. We may require that a Physician chosen by us examine the child. We will pay for that examination.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Policy.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

## Continuation of Coverage and Conversion

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

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

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

If an Eligible Person leaves state employment because of involuntary lay off as a result of the workplace ceasing to exist or the permanent reduction in size of the workforce, the benefits under the Plan or a spouse's coverage under the Plan may be continued under the provision R.I. Gen. Laws 27-19.1-1, as amended. If an Eligible Person dies, his/her spouse's coverage may be continued under the same law.

If We cease to offer medical coverage to our employees or replace our self-insured medical plan with a fully-insured medical plan, limited coverage will continue for twelve (12) months for those members who are totally disabled on the day the Plan ends and require continued care. Services will be covered if:

- the service provided is a Covered Health Service under the Plan; AND
- the care received relates to or arises out of the disability that existed on the day the Plan ended.

Such extended benefits ONLY apply if you are totally disabled. If you desire to receive this coverage, you must provide us with proof of total disability. Your coverage will NOT be continued if you become eligible for coverage under another employer/agent's plan.

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## Continuation Coverage under Federal Law (COBRA)

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

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

- A Participant.
- A Participant's Enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law. However, domestic partners and civil union spouses of Participants are not eligible for continuation coverage under federal law (COBRA).

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

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

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

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- A. Termination of employment, for any reason other than gross misconduct.
- B. Reduction in the Participant's hours of employment.

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

- A. Termination of the Participant's employment (for reasons other than the Participant's gross misconduct).
- B. Reduction in the Participant's hours of employment.
- C. Death of the Participant.
- D. Divorce or legal separation of the Participant.
- E. Loss of eligibility by an Enrolled Dependent who is a child.
- F. Entitlement of the Participant to Medicare benefits.
- G. The Plan Sponsor's commencement of a bankruptcy under Title 11, United States Code. This is also a qualifying event for any retired Participant and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

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

### *Notification Requirements for Qualifying Event*

The Participant or other Qualified Beneficiary must notify the Plan Administrator within 60 days of the latest of the following events:

- The Participant's divorce or legal separation, or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent.

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- The date the Qualified Beneficiary would lose coverage under the Plan.
- The date on which the Qualified Beneficiary is informed of his or her obligation to provide notice and the procedures for providing such notice.

The Participant or other Qualified Beneficiary must also notify the Plan Administrator when a second qualifying event occurs, which may extend continuation coverage.

If the Participant or other Qualified Beneficiary fails to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If a Participant is continuing coverage under federal law, the Participant must notify the Plan Administrator within 60 days of the birth or adoption of a child.

***Notification Requirements for Disability Determination or Change in Disability Status***

The Participant or other Qualified Beneficiary must notify the Plan Administrator as described under "Terminating Events for Continuation Coverage under federal law (COBRA)", subsection A. below.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Attachment II to this Summary Plan Document. The contents of the notice must be such that the Plan Administrator is able to determine the covered employee and Qualified Beneficiary or Qualified Beneficiaries, the qualifying event or disability, and the date on which the qualifying event occurred.

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None of the above notice requirements will be enforced if the Participant or other Qualified Beneficiary is not informed of his or her obligations to provide such notice.

After providing notice to the Plan Administrator, the Qualified Beneficiary shall receive the continuation coverage and election notice. Continuation coverage must be elected by the later of 60 days after the qualifying event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the Plan Administrator.

The Qualified Beneficiary's initial premium due to the Plan Administrator must be paid on or before the 45th day after electing continuation.

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

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Participant must contact the Plan Administrator promptly after qualifying for assistance under the

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Trade Act of 1974 or the Participant will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

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

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

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

If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at any time within the first 60 days of continuation coverage for qualifying event A. then the Qualified Beneficiary may elect an additional eleven months of continuation coverage (for a total of twenty-nine months of continued coverage) subject to the following conditions:

— Notice of such disability must be provided within the latest of 60 days after:

- ◆ the determination of the disability; or
- ◆ the date of the qualifying event; or
- ◆ the date the Qualified Beneficiary would lose coverage under the Plan; and
- ◆ in no event later than the end of the first eighteen months.

— The Qualified Beneficiary must agree to pay any increase in the required premium for the additional eleven months.

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- If the Qualified Beneficiary who is entitled to the eleven months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional eleven months of continuation coverage.

Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

- B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Participant, divorce or legal separation of the Participant, or loss of eligibility by an Enrolled Dependent who is a child (i.e. qualifying events C., D., or E.).

- C. With respect to Qualified Beneficiaries, and to the extent that the Participant was entitled to Medicare prior to the qualifying event:

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

- Thirty-six months from the date of the Participant's Medicare entitlement, if a second qualifying event (that was due to either the Participant's termination of employment or the Participant's work hours being reduced) occurs prior to the expiration of the eighteen months.

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- D. With respect to Qualified Beneficiaries, and to the extent that the Participant became entitled to Medicare subsequent to the qualifying event:
- Thirty-six months from the date of the Participant's termination from employment or work hours being reduced (first qualifying event) if:
    - ◆ the Participant's Medicare entitlement occurs within the eighteen month continuation period; and
    - ◆ if, absent the first qualifying event, the Medicare entitlement would have resulted in a loss of coverage for the Qualified Beneficiary under the group health plan.
- E. The date coverage terminates under the Plan for failure to make timely payment of the premium.
- F. The date, after electing continuation coverage, that coverage is first obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any pre-existing condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.
- G. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event G.). If the Qualified Beneficiary was entitled to continuation because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event G.) and the retired Participant dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for thirty-six months from the date of the Participant's death.

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- H. The date the entire Plan ends.
- I. The date coverage would otherwise terminate under the Plan as described in this section under the heading *Events Ending Your Coverage*.

## Conversion

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

Reasons for termination:

- You cease to be eligible as a Participant or Enrolled Dependent.
- Continuation coverage ends.

This right to conversion coverage is contingent upon the exhaustion of COBRA continuation coverage.

See also Continuation of Coverage and Conversion section above.

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

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## Section 9: General Legal Provisions

This section provides you with information about:

- General legal provisions concerning the Plan.

### Plan Document

This Summary Plan Document presents an overview of your Benefits. In the event of any discrepancy between this Summary Plan Document 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, nor are the Claims Administrator and any of its employees agents or employees of Network providers.

We and the Claims Administrator do not provide health care services or supplies, nor do we practice medicine. Instead, we and the Claims Administrator arrange for health care providers to participate in a Network to pay Benefits. Network providers are independent practitioners who run their own offices and facilities.

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The Claims Administrator's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. We and the Claims Administrator do not have any other relationship with Network providers such as principal-agent or joint venture. We and the Claims Administrator are not liable for any act or omission of any provider.

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

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

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

### Your Relationship with Providers

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

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

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- 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.

## 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.

## Interpretation of Benefits

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

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

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

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

## Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

## Amendments to the Plan

Plan Amendments and Riders are effective on the date specified.

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

Any change or amendment to or termination of the Plan, its benefits or its terms and conditions, in whole or in part, shall be made solely in a written amendment (in the case of a change or amendment) or in a written resolution (in the case of a termination), whether prospective or retroactive, to the Plan, in accordance with the procedures established by us. Covered Persons will receive notice of

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any material modification to the Plan. No one has the authority to make any oral modification to the SPD.

## **Clerical Error**

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

## **Information and Records**

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

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

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

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

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

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.

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## Medicare Eligibility

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

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

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you **should** enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are the secondary payer as described in Section 7: Coordination of Benefits, we will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

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

## Subrogation and Reimbursement

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

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### *Right to Subrogation*

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

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

### *Right to Reimbursement*

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

### *Third Parties*

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused the Sickness, Injury, or damages.

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- Any person or entity who is or may be obligated to provide you with benefits or payments under:
  - Underinsured or uninsured motorist insurance.
  - Medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise).
  - Workers' compensation coverage.
  - Any other insurance carrier or third party administrator.

### ***Subrogation and Reimbursement Provisions***

As a Covered Person, you agree to the following:

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds you recover from a third party.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- The Plan may enforce its subrogation and reimbursement rights regardless of whether you have been "made whole" (fully compensated for your injuries and damages).

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- You will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - Complying with the terms of this section.
  - Providing any relevant information requested.
  - Signing and/or delivering documents at its request.
  - Appearing at medical examinations and legal proceedings, such as depositions or hearings.
  - Obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.
- If you receive payment as part of a settlement or judgment from any third party as a result of a Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- You will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a Sickness or Injury caused by a third party.
- The Plan's rights will not be reduced due to your own negligence.

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- The Plan may file suit in your name and take appropriate action to assert its rights under this section. The Plan is not required to pay you part of any recovery it may obtain from a third party, even if it files suit in your name.
- The provisions of this section apply to the parents, guardian, or other representative of an Enrolled Dependent child who incurs a Sickness or Injury caused by a third party.
- In case of your wrongful death, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs.
- Your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.
- If a third party causes you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Covered Person.

## 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.

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- 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

You cannot bring any legal action against us to recover reimbursement prior to the expiration of sixty days after a request for benefits has been filed, and no such action can be brought at all unless brought within three years from the expiration of time to submit a request for benefits.

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## Section 10: Glossary of Defined Terms

This section:

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

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

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

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

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

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

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

**Cancer Resource Services Program** – the program made available by the Plan Sponsor to Participants. The Cancer Resource Services Program provides information to Participants or their Enrolled Dependents with cancer and offers access to additional cancer centers for the treatment of cancer.

**Chiropractic 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.

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

**Common Law Spouse** – your spouse by common law of the opposite sex is eligible to enroll for coverage under this Plan if you and your Common Law Spouse complete and sign our Affidavit of Common Law Marriage and we receive the necessary proof, as determined by us.

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

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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. Copays apply to the Out-of-Pocket Maximum.

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

**Covered Health Service(s)** - those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, Substance Use, 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. If a service or category of service is not listed as covered, it is not covered under this plan. All other services are non-covered (excluded).

**Covered Person** - either the Participant or an Enrolled Dependent, but this term applies only while the person is enrolled under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

**Custodial Care** - services that:

- Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); or
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or

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

**Dependent** - the Participant's legal spouse or an unmarried dependent child of the Participant or the Participant's spouse. All references to the spouse of a Participant shall include a Domestic Partner or civil union spouse. Only one of the following persons can be eligible to enroll under family coverage with you at the same time.

- Spouse: Your lawful spouse, according to the statutes of the state in which you were married, is eligible to enroll for coverage under this plan.
- Common Law Spouse: Your spouse by common law of the opposite gender is eligible to enroll for coverage under this plan if you and your Common Law Spouse complete and sign our Affidavit of Common Law Marriage and we receive the necessary proof, as determined by us.
- Domestic Partner: Your domestic partner, as defined under Rhode Island law, is eligible to enroll for coverage under this plan if you complete and sign the Plan Administrator's Affidavit of Domestic Partnership.

The term child includes any of the following children of the Participant:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child of a civil union spouse.
- A child placed for adoption.

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- A child for whom legal guardianship has been awarded to the Participant or the Participant's spouse.
- A foster child permanently living with an eligible Participant.

A Dependent also includes a child for whom health care coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order (QMCSO).

You must provide satisfactory proof as determined by the Plan Administrator to enroll your adopted children, step-children, foster children, or children who will be considered eligible due to a QMCSO.

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

- A Dependent includes any dependent child to the end of the calendar month in which they reach 26 years of age.
- A Dependent includes any unmarried dependent child of any age who is medically certified as disabled and is unable to support himself or herself because of such disability, provided however, that the child is chiefly dependent upon the Participant for support and care because of a mental impairment or physical disability which can be expected to result in death or can be expected to last for a continuous period of not less than 12 months. If an eligible retiree has a disabled child, he or she must fill out a special application. In the application, the eligible retiree must show proof of the child's disability. We may require that a Physician chosen by us examine the child. We will pay for that examination. We may continue to ask for and you will be required to submit proof that the child continues to meet these

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conditions of disability and dependency. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

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

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

**Domestic Partner** – a person of the opposite or same sex with whom the Participant has established a Domestic Partnership, pursuant to Rhode Island General Law 36-12.1.

**Durable Medical Equipment** - medical equipment (and supplies necessary for the effective use of equipment) that is all of the following:

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

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**Eligible Expenses** - for Covered Health Services incurred while the Plan is in effect, Eligible Expenses are determined as stated below:

For Network Benefits, Eligible Expenses are based on either of the following:

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

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from non-Network providers, Eligible Expenses are determined, at the Claims Administrator's discretion, based on:
  - Available data resources of competitive fees in that geographic area.
  - The Claims Administrator's most commonly used contracted fee(s) with Network providers for the same or similar service within the geographic market or the amount determined by the Claims Administrator which Network providers have agreed to accept as payment in full.

Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines. The reimbursement policy guidelines are developed, in the Claims Administrator's discretion, following evaluation and validation of all

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provider billings in accordance with one or more of the following methodologies:

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

**Eligible Person** - a retired full-time employee of the Plan Sponsor who was scheduled to work at his or her job at least 20 hours per week. An Eligible Person shall also include members of the General Assembly and excludes Clerk, Door Keepers and Pages.

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

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

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

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

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

- not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational); or
- the subject of an ongoing Clinical Trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under Clinical Trials in Section 1: *What's Covered – Benefits*
- If you are not a participant in a qualifying Clinical Trial as described under Section 1: *What's Covered - Benefits* and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator

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must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

**Home Health Care Agency** - a program or organization authorized by law to provide health care services in the home, including medically necessary programs to reduce the length of a hospital stay or to eliminate or delay a hospital admission.

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

- Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- Has 24 hour nursing services.
- Either listed as a hospital by the American Hospital Association or accredited by JCAHO (Joint Commission on Accreditation of Health Care Organizations).

A Hospital is not primarily a place for rest, custodial care or care of the aged and is not a nursing home, convalescent home institution, rest home, nursing home, school/college infirmary, halfway house or residential facility, long-term care facility, free-standing emergency medical center or free-standing ambulatory surgi-center, facility providing primarily custodial, educational, or rehabilitative care, or sections of hospitals used for these purposes.

- A **General Hospital** means a Hospital which is designed to care for medical and surgical patients with acute illness or injury.
- A **Specialty Hospital** means a Hospital or the specialty unit of a General Hospital which is licensed by the State and designed to care for patients with injuries or special illnesses, including but not limited to a mental health rehabilitation unit or hospital.

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**Hospital Services** - are the following in-hospital services:

- Anesthesia supplies;
- Blood services including: administration, typing, cross matching, drawing maintenance of donor room, and charges for plasma and derivatives. Charges for whole blood, red blood cells and blood replacement costs and penalty fees are NOT covered;
- Cardiac pacemakers;
- Chemotherapy and radiation (Note: coverage of high dose chemotherapy and/or radiation services related to autologous bone marrow transplantation is limited.
- Computerized axial tomography (CAT or CT scan) and magnetic resonance imaging (MRI).
- Diagnostic X-rays, radiotherapy and diagnostic and therapeutic radioisotopic services;
- Drugs and medications as currently listed in the National Formulary or the U.S. Pharmacopeia;
- Electrocardiograms (EKGs) and electro-encephalogram (EEG);
- General nursing care; AND
- Hearing evaluation;
- Hemodialysis – use of machine and other physical equipment;
- Inhalation and oxygen therapy;
- Insulin and shock therapy;
- Laboratory examinations and pulmonary function tests;
- Mammogram;
- Meals and other dietary services;
- Medical and surgical supplies;

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- Durable medical equipment;
- Occupational therapy;
- Original prosthetic and initial prosthesis when provided and billed for by the hospital where you are an inpatient or the hospital where you return within a reasonable period of time for an initial prosthesis or original prosthetic, providing the prosthesis or the prosthetic is related to the original hospital stay;
- Pap smear;
- Physical therapy;
- Respiratory therapy services;
- Recovery room;
- Room accommodations in a ward or semi-private room;
- Services performed in intensive care units;
- Services of a licensed clinical psychologist when ordered by a doctor and billed by a hospital;
- Speech evaluation and therapy;
- Ultrasonography (ultrasounds);
- Use of the operating room;
- Other hospital services necessary for your treatment which we have approved.

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

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

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**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.

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

**Medical Supplies** - those consumable supplies which are disposable and not intended for reuse. These supplies are ordered by a physician and are essential for the care or treatment of an illness, injury or congenital defect.

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

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

**Mental Health/Substance Use Disorder (MH/SUD)**

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

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**Mental Illness** - any mental health or psychiatric diagnostic categories listed in the American Psychiatric Association's current *Diagnostic and Statistical Manual of Mental Disorders*, unless they are listed in the exclusions section of this SPD

**Network** - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with the Claims Administrator's affiliate to participate in the Claims Administrator's Network however, this does not include those providers who have agreed to discount their charges for Covered Health Services.. The Claims Administrator's affiliates are those entities affiliated with them through common ownership or control with the Claims Administrator or with its ultimate corporate parent, including direct and indirect subsidiaries.

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

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

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

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**Open Enrollment Period** - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Plan, as determined by us.

**Out-of-Pocket Maximum** -

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

The following costs will apply to the Out-of-Pocket Maximum:

- Copays, except for those Covered Health Services identified in Section 1: *What's Covered - Benefits* table that do not apply to the Out-of-Pocket Maximum
- Coinsurance Payments, except for those Covered Health Services identified in Section 1: *What's Covered - Benefits* table that do not apply to the Out-of-Pocket Maximum

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

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

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- Copayments for 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.

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

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

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

Please Note: Any marriage and family therapist, mental health counselor, midwife, nurse anesthetist, nurse first assistant, nurse practitioner 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** - 2014 Early Retire Choice Plus Plan for State of Rhode Island Health Benefit Plan.

**Plan Administrator** - is State of Rhode Island or its designee.

**Plan Sponsor** - State of Rhode Island. References to "we", "us", and "our" throughout the SPD refer to the Plan Sponsor.

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

- Prenatal care.
- Postnatal care.

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- Childbirth.
- Any complications associated with Pregnancy.

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

- it is established and operated in accordance with applicable state law for residential treatment programs;
- it provides a program of treatment under the active participation and direction of a Physician and approved by the Substance Use Disorder Administrator;
- it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- it provides at least the following basic services in a 24-hour per day, structured milieu:
  - room and board;
  - evaluation and diagnosis;
  - counseling; and
  - referral and orientation to specialized community resources.

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

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

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

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

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

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

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

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

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

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.

Except as set forth in Section 1: What's Covered – Benefits; 2. Cancer Therapies – Investigational and 17. Lyme Disease, if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we and the Claims Administrator may, in our discretion, determine that an Unproven Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we and the Claims Administrator must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

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

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# Riders, Amendments, Notices

Attachment I

Attachment II

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# Attachment I

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

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

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

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

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as

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

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

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (*e.g.*, your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

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# Attachment II

obstetrics or gynecology, contact the Claims Administrator at the toll-free number on the back of your ID card.

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

### *Patient Protection Notices*

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator’s network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the toll-free number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator’s network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in

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