HANFORD EMPLOYEE WELFARE TRUST (HEWT)

SUMMARY PLAN DESCRIPTION

"OPTIONS PPO "Medical Plan

for

Active Employees

Effective Date: January 1, 2003

Medical Claims Administered by UnitedHealthcare

Group Number: 702633

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Introduction

The Hanford Employee Welfare Trust (HEWT) is pleased to provide you with this Summary Plan Description (SPD) which describes your Benefits, as well as your rights and responsibilities, under the Plan.

You and your dependents are eligible for this plan if you are an Eligible Person as defined in Section 10: Glossary of Defined Terms, and you are employed by a Sponsoring Employer listed in Attachment II.

This document describes Benefits for two plans:

1. The ***HEWT Options Medical Plan for Active Employees*** - applies to all enrolled active employees (and their Eligible Dependents) whose homes are located in an area in which UnitedHealthcare network providers are available.

2. The ***HEWT Out-of-Area Medical Plan for Active Employees*** - applies ONLY to active employees (and their dependents) whose homes are NOT located in an areas in which UnitedHealthcare network providers are available. This plan will apply only rare circumstances because the UnitedHealthcare PPO network covers a majority of the United States. UnitedHealthcare can confirm whether this plan applies to you.

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How to Use This Document

We encourage you to read this SPD and all attached Riders and Amendments carefully. Many of the sections relate to other sections of the document. You may not have all of the information you need by reading just one section. We especially encourage you to review Section 1: What's Covered – Benefits, Section 2: What's Not Covered – Exclusions, and Section 9: General Legal Provisions.

Keep this SPD and other documents related to your Medical Plan in a safe place for future reference.

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

Information About Defined Terms

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

The words "we," "us," and "our" in this document refer to the ***Plan Administrator*** which is the Hanford Employee Welfare Trust (HEWT). The words "you" and "your" refer to Employees and Dependents who are Covered Persons as the term is defined in Section 10: Glossary of Defined Terms.

Your Contribution Towards Plan Costs

The Plan requires Employees to contribute towards the cost of the coverage. Contact the Plan Administrator or your employer for

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information about the portion of the plan cost for which you may be responsible.

Customer Service and Claims Submittal

The term ***Claims Administrator*** refers to UnitedHealthcare. Following are important Claims Administrator department names and toll free telephone numbers:

Customer Service Representative
(questions regarding coverage or claims)**:** **1-(866) 249-7606**

Care Coordination/Notification **1-(866) 249-7606**

Mental Health/Substance Abuse Services: 1-(866) 249-7606

Spectera Vision **1-(800)-839-3242**

Prescription Drug Program: See Page 105

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Claims Submittal Address:

United HealthCare Insurance Company

P.O. Box 30555

Salt Lake City, Utah 84130-0555

Requests for Review of Denied Claims and Notice of Complaints:

Name and Address For Submitting Requests:

United HealthCare Insurance Company

P.O. Box 30555

Salt Lake City, Utah 84130-0555

Internet:

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

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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 Care Coordination[SM] before you receive them.

Accessing Benefits

Under the Options PPO Plan, you can choose to receive either PPO Network Benefits or PPO Non-Network Benefits. To obtain PPO Network Benefits you must see a Network Physician or other Network provider.

Under the Out-of-Area Plan, you can choose to receive Benefits from any Physician or provider. Depending on the geographic area, you may have access to Network providers. These providers have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from a Network provider, your

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

Copayment level will remain the same. However, the portion that you owe may be less than if you received services from a non-Network provider because the Eligible Expense may be a lesser amount.

For the PPO Plan, 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 the Out-of-Area Plan, you should show your identification card (ID card) every time you request health care services so that the provider will know that you are enrolled under the Plan.

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

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

Copayment/Coinsurance

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.

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Eligible Expenses

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

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

For PPO Network Benefits, you are not responsible for any difference between the Eligible Expenses and the amount the provider bills, unless you agreed to reimburse the provider for such services. For PPO 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.

Notification Requirements

Prior notification is required before you receive certain Covered Health Services. You are responsible for notifying Care Coordination℠ before you receive these Covered Health Services.

For Mental Health/Substance Abuse Services you are responsible for notifying the Mental Health/Substance Abuse Designee.

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

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

To notify Care Coordination℠ or the Mental Health/Substance Abuse Designee, call the toll free telephone number shown on your ID card, 1-866-249-7606, for Claims Administration.

We urge you to confirm with Care Coordination℠ that the services you plan to receive are Covered Health Services, even if not indicated in the *Must You Notify Care Coordination℠?* column. That's because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling the toll free telephone number shown on your ID card, 1-866-249-7606, before you receive treatment, you can check to see if the service is subject to limitations or exclusions such as:

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

Special Note Regarding Medicare

If you are enrolled for Medicare on a primary basis (Medicare pays before we pay Benefits under the Plan), the notification requirements described in this SPD do not apply to you. 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 Care Coordination℠ before receiving Covered Health Services when Medicare is the primary payer.

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

Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services before you are eligible to receive Benefits. For a complete definition of Annual Deductible, see Section 10: Glossary of Defined Terms.	***PPO Network/Out-of-Area*** $200 per Covered Person per calendar year. Family deductible is met once two Covered Persons each meet the individual deductible. The family deductible is $400 for all Covered Persons in a family. ***PPO Non-Network*** $300 per Covered Person per calendar year. Family deductible is met once two Covered Persons each meet the individual deductible. The family deductible is $600 for all Covered Persons in a family. ***Mental Health and Substance Abuse PPO Network*** There is no deductible for in-network Mental Health and Substance Abuse. ***Mental Health and Substance Abuse PPO Non-Network or Out-of-Area*** $300 per Covered Person per calendar year. Family deductible is met once three Covered Persons each meet the individual deductible. The family deductible is $900 for all Covered Persons in a family.
Out-of-Pocket Maximum	The maximum you pay, out of your pocket, in a calendar year for Copayments. For a complete definition of Out-of-Pocket Maximum, see Section 10: Glossary of Defined Terms.	***PPO Network/Out-of-Area Plan*** $1,000 per Covered Person per calendar year. Family is met once two Covered Persons each meet the individual out-of-pocket maximum. The family out-of-pocket maximum is $2,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible. ***PPO Non-Network*** $3,000 per Covered Person per calendar year. Family is met once two Covered Persons each meet the individual out-of-pocket maximum. The family out-of-pocket maximum is $6,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible.

Payment Term	Description	Amounts
Maximum Plan Benefit	The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Plan. For a complete definition of Maximum Plan Benefit, see Section 10: Glossary of Defined Terms.	$1,500,000 per Covered Person.

Benefit Information

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
1. Acupuncture Services Acupuncture services for pain therapy when both of the following are true: • Another method of pain management has failed. • The service is performed by a provider in the provider's office. Where such Benefits are available, acupuncture is a Covered Health Service for the treatment of: • Nausea of Chemotherapy, or • Post-operative nausea, or • Nausea of early Pregnancy. Any combination of PPO Network and PPO Non-Network Benefits are limited to 20 visits per calendar year. Benefits are limited to 20 visits per calendar year under the Out-of-Area Plan	***PPO Network*** No	15%	Yes	Yes
	PPO Non-Network No	15%	Yes	Yes
	Out-of-Area No	15%	Yes	Yes
2. Ambulance Services - Emergency only Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.	***PPO Network*** No	*Ground Transportation:* 15%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
	PPO Network No	*Air Transportation:* 15%	Yes	Yes
	PPO Non-Network No	Same as PPO Network	Yes	Yes
	Out-of-Area No	Same as PPO Network	Yes	Yes
3. Ambulance Services - Non-Emergency Transportation by professional ambulance, other than air ambulance, to and from a medical facility. Transportation by regularly-scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment.	***PPO Network*** No	*Ground Transportation:* 40% *Air Transportation:* 40%	Yes	Yes
	PPO Non-Network No	Same as PPO Network	Yes	Yes
	Out-of-Area No	Same as PPO Network	Yes	

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
				Yes
4. Dental Services - Accident only	***PPO Network***			
Dental services when all of the following are true:	Yes	15%	Yes	Yes
• Treatment is necessary because of accidental damage. • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D." • The dental damage is severe enough that initial contact with a Physician or dentist occurred within 48 hours of the accident.	***PPO Non-Network*** Yes	40%	Yes	Yes
Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was:	***Out-of-Area*** Yes	15%	Yes	Yes
• A virgin or unrestored tooth, or • A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.				
Dental services for final treatment to repair the damage must be both of the following:				
• Started within three months of the accident. • Completed within 12 months of the accident.				
Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to				

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
teeth that are injured as a result of such activities. **Notify Care Coordination℠** Please remember that you should notify Care Coordination℠ as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. (You do not have to provide notification before the initial Emergency treatment.) When you provide notification, Care Coordination℠ can verify that the service is a Covered Health Service.				
5. Durable Medical Equipment Durable Medical Equipment that meets each of the following criteria: • Ordered or provided by a Physician for outpatient use. • Used for medical purposes. • Not consumable or disposable. • Not of use to a person in the absence of a disease or disability. If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment. Examples of Durable Medical Equipment include: • Equipment to assist mobility, such as a standard wheelchair. • A standard Hospital-type bed. • Oxygen concentrator units and the rental of equipment to	***PPO Network*** Yes, for items more than $1,000.	15%	Yes	Yes
	PPO Non-Network Yes, for items more than $1,000.	40%	Yes	Yes
	Out-of-Area Yes, for items more than $1,000.	15%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
administer oxygen. • Delivery pumps for tube feedings. • Braces that stabilize an Injured body part are considered Durable Medical Equipment and are a Covered Health Service, including necessary adjustments to shoes to accommodate braces. • Mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions. We provide Benefits for a single unit of Durable Medical Equipment (example one insulin pump) and provide repair for that unit. Benefits are provided for the replacement of a type of Durable Medical Equipment once every three calendar years. Care Coordination℠ will decide if the equipment should be purchased or rented. You must purchase or rent the Durable Medical Equipment from the vendor Care Coordination℠ identifies. Benefits for the purchase and repair of Durable Medical Equipment is limited to $50,000 per lifetime. **Notify Care Coordination℠** Please remember that you must notify Care Coordination℠ before obtaining any single item of Durable Medical Equipment that costs more than $1,000 (either purchase price or cumulative rental of a single item).				
6. Emergency Health Services Services that are required to stabilize or initiate treatment in an	***PPO Network*** Yes, but only for an Inpatient	$50 per visit plus 15%	No Yes	Yes Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.	Stay.			
You will find more information about Benefits for Emergency Health Services in Section 3: Obtaining Benefits.	***PPO Non-Network***	$50 per visit plus 15%	No Yes	Yes Yes
	Yes, but only for an Inpatient Stay.			
Notify Care Coordination℠ To ensure prompt and accurate payment of your claim as a PPO Network Benefit, notify Care Coordination℠ within two business days or as soon as possible after you receive outpatient Emergency Health Services at a non-Network Hospital or Alternate Facility.	***Out-of-Area*** Yes, but only for an Inpatient Stay.	$50 per visit plus 15%	No Yes	Yes Yes
Please remember that if you are admitted to a Hospital as a result of an Emergency, you must notify Care Coordination℠ within two business days or the same day of admission, or as soon as reasonably possible.				
If you don't notify Care Coordination℠, Benefits for the Hospital Inpatient Stay will be reduced to 40% of Eligible Expenses. Benefits will not be reduced for the outpatient Emergency Health Services.				
7. Hearing Care Benefits include one annual routine hearing screening to detect hearing impairment.	***PPO Network*** No	15%	Yes	Yes
Benefits for hearing aids are covered up to $300 in a 36 month	***Non PPO***			

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
period.	***Network*** No	40%	Yes	Yes
Please note that Benefits are not available for charges connected to batteries and the replacement of hearing aids.	***Out-of-Area*** No	15%	Yes	Yes
8. Home Health Care Services received from a Home Health Agency that are both of the following:	***PPO Network*** Yes	15%	Yes	Yes
• Ordered by a Physician. • Provided by or supervised by a registered nurse in your home.				
Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled home health care is required.	***PPO Non-Network*** Yes	40%	Yes	Yes
Skilled home health care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:	***Out-of-Area*** Yes	15%	Yes	Yes
• 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.				

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• It requires clinical training in order to be delivered safely and effectively. • It is not Custodial Care. Care Coordination℠ will decide if skilled home health care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver. Any combination of PPO Network and PPO Non-Network Benefits are limited to 40 visits per calendar year. Out-of-Area Benefits are limited to 40 visits per calendar year One visit equals four hours of skilled care services. **Notify Care Coordination℠** Please remember that you should notify Care Coordination℠ five business days before receiving services. If you don't notify Care Coordination℠, Benefits will be reduced to 40% of Eligible Expenses.				
9. Hospice Care Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed hospice	***PPO Network*** Yes	0%	N/A	No
	PPO Non-Network Yes	0%	N/A	No

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
agency.				
Notify Care Coordination℠ Please remember that you must notify Care Coordination℠ five business days before receiving services. If you don't notify Care Coordination℠, Benefits will be reduced to 40% of Eligible Expenses.	***Out-of Area*** Yes	0%	N/A	No
10. Hospital - Inpatient Stay Inpatient Stay in a Hospital. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds).	***PPO Network*** Yes	15%	Yes	Yes
Notify Care Coordination℠ Please remember that you must notify Care Coordination℠ as follows: • For elective admissions: five business days before admission. • For non-elective admissions: within one business day or the same day of admission. • For Emergency admissions: within two business days or the same day of admission, or as soon as is reasonably possible. If you don't notify Care Coordination℠, Benefits will be reduced to 40% of Eligible Expenses.	***PPO Non-Network*** Yes	40%	Yes	Yes
	Out-of-Area Yes	15%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
11. Injections received in a Physician's Office Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.	***PPO Network*** No	15% per injection	Yes	Yes
	PPO Non-Network No	40% per injection	Yes	Yes
	Out-of-Area No	15% per injection	Yes	Yes
12. Maternity Services Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. There is a special prenatal program to help during Pregnancy. It is completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify Care Coordination℠ during the first trimester, but no later than one month prior to the anticipated childbirth. We will pay Benefits for an Inpatient Stay of at least: • 48 hours for the mother and newborn child following a vaginal delivery. • 96 hours for the mother and newborn child following	***PPO Network*** Yes if Inpatient Stay exceeds time frames.	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.		
	PPO Non-Network Yes if Inpatient Stay exceeds time frames.	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.		
	Out-of-Area Yes if Inpatient Stay exceeds time frames.	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.		

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
a cesarean section delivery. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. **Notify Care Coordination℠** Please remember that you must notify Care Coordination℠ as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described. If you don't notify Care Coordination℠ that the Inpatient Stay will be extended, your Benefits for the extended stay will be reduced to 40% of Eligible Expenses.				
13. Mental Health and Substance Abuse Services - Outpatient Mental Health Services and Substance Abuse Services received on an outpatient basis in a provider's office or at an Alternate Facility, including: • Mental health, substance abuse and chemical dependency evaluations and assessment. • Diagnosis. • Treatment planning. • Referral services. • Medication management. • Short-term individual, family and group therapeutic services (including intensive outpatient therapy).	***PPO Network*** You must call the Mental Health/ Substance Abuse Designee to receive the Benefits.	$15 per individual visit; $5 per group visit.	No	No

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Crisis intervention. • Psychological testing.				
For PPO Network Benefits, referrals to a Mental Health/Substance Abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding PPO Network Benefits for outpatient Mental Health and Substance Abuse Services prior to receiving services. PPO Network Benefits for Mental Health Services and/or Substance Abuse Services is limited to 60 visits per calendar year.	***PPO Non-Network*** You must call the Mental Health/ Substance Abuse Designee to receive the Benefits.	50%	No	Yes
PPO Non-Network Benefits for Mental Health Services is limited to 25 visits per calendar year. PPO Non-Network Benefits for Substance Abuse Services is limited to 25 visits per calendar year. Any combination of PPO Network and PPO Non-Network Benefits for Mental Health Services and/or Substance Abuse Services is limited to 60 visits per calendar year. Out-of-Area Benefits are limited to 60 visits per calendar year.	***Out-of-Area*** You must call the Mental Health/ Substance Abuse Designee to receive the Benefits.	15%	No	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Authorization Required Please remember that you must call and get authorization to receive these Benefits in advance of any treatment through the Mental Health/Substance Abuse Designee. The Mental Health/Substance Abuse Designee phone number, 1-866-249-7606, also appears on your ID card. PPO Network Benefits, without authorization, will be subject to a $250 penalty. PPO Non-Network Benefits, without authorization, will be reduced by 40% of Eligible Expenses. Out-of-Area Benefits, without authorization, will be subject to a $250 penalty.	***Treatment Site:*** - Residential treatment - Day treatment/partial hospitalization - Structured outpatient - Sober living/transitional living - Outpatient psychotherapy visit		***Ratio*** 1.5 days = 1 Inpatient day 2 days = 1 Inpatient day 5 days = 1 Inpatient day 10 days = 1 Inpatient day 6 days = 1 Inpatient day	
14. Mental Health and Substance Abuse Services - Inpatient and Intermediate Mental Health Services and Substance Abuse Services received on an inpatient or intermediate care basis in a Hospital or an Alternate Facility. Benefits include detoxification from abusive chemicals or substances that is limited to physical detoxification when necessary to protect your physical health and well-being.	***PPO Network*** You must call the Mental Health/ Substance Abuse Designee to receive the Benefits.	0% Mental Health and Substance Abuse	N/A	No

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
The Mental Health/Substance Abuse Designee, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. At the discretion of the Mental Health/Substance Abuse Designee, two sessions of intermediate care (such as partial hospitalization) may be substituted for one inpatient day. PPO Network Benefits for Mental Health Services and Substance Abuse Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. For PPO Network Benefits, referrals to a Mental Health/Substance Abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for inpatient/intermediate Mental Health Services and Substance Abuse Services. PPO Non-Network Benefits for Mental Health Services is limited to 20 days per calendar year. PPO Non-Network Benefits for Substance Abuse Services is limited to 20 days per calendar year. PPO Network Benefits for Mental Health Services and/or Substance Abuse Services is limited to 60 days per calendar year. Any combination of Network and PPO Non-Network Benefits for Mental Health Services and/or Substance Abuse Services is limited	***PPO Non-Network*** You must call the Mental Health/ Substance Abuse Designee to receive the Benefits.	40% Mental Health 50% Substance Abuse up to a total of $5,000 per calendar year.	No	Yes
	Out-of-Area You must call the Mental Health/ Substance Abuse Designee to receive the Benefits.	15% Mental Health and Substance Abuse	No	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
to 60 days per calendar year. Out-of-Area Benefits are limited to 60 visits per calendar year. **Authorization Required** Please remember that you must call and get authorization to receive these Benefits in advance of any treatment through the Mental Health/Substance Abuse Designee. The Mental Health/Substance Abuse Designee phone number, 1-866-249-7606, also appears on your ID card. PPO Network Benefits, without authorization, will be subject to a $250 penalty. PPO Non-Network Benefits, without authorization, will be reduced by 40% of Eligible Expenses. Out-of-Area Benefits, without authorization, will be subject to a $250 penalty.				
15. Nutritional Counseling Covered Health Services provided by a registered dietician in an individual session for Covered Persons with medical conditions that require a special diet. Some examples of such medical conditions include: • Diabetes mellitus. • Coronary artery disease. • Congestive heart failure. • Severe obstructive airway disease.	***PPO Network*** No	15%	Yes	Yes
	PPO Non-Network No	40%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Gout. • Renal failure. • Phenylketonuria. • Hyperlipidemias. Benefits are limited to three individual sessions during a Covered Person's lifetime for each medical condition.	***Out-of-Area*** No	15%	Yes	Yes
16. Outpatient Surgery, Diagnostic and Therapeutic Services Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including: • Surgery and related services. • Lab and radiology/X-ray. • Mammography testing. • Other diagnostic tests and therapeutic treatments (including cancer chemotherapy or intravenous infusion therapy). Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient surgery, diagnostic and therapeutic services are described under *Professional Fees for Surgical and Medical Services* below. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.	***PPO Network*** No	15%	Yes	Yes
	PPO Non-Network No	40%	Yes	Yes
	Out-of-Area No	15%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
17. Physician's Office Services Covered Health Services received in a Physician's office including: • Treatment of a Sickness or Injury. • Voluntary family planning. • *Preventive medical care. • *Well-baby and well-child care. • *Routine well woman examinations, including pap smears, pelvic examinations and mammograms. • *Routine physical examinations. • *Immunizations.	***PPO Network*** No	Non-Preventive Care 15%	Yes	Yes
	PPO Network No	*Preventive Care 0%	N/A	No
	PPO Non-Network No	40%	Yes	Yes
	Out-of-Area No	15%	Yes	Yes
18. Professional Fees for Surgical and Medical Services Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.	***PPO Network*** No	15%	Yes	Yes
	PPO Non-Network No	40%	Yes	Yes
	Out-of-Area No	15%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
19. Prosthetic Devices Prosthetic devices that replace a limb or body part including: • Artificial limbs. • Artificial eyes. • Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998.	***PPO Network*** No	15%	Yes	Yes
If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.	***PPO Non-Network*** No	40%	Yes	Yes
The prosthetic device must be ordered or provided by, or under the direction of a Physician. We provide Benefits for a single purchase, including repairs, of a type of prosthetic device. Benefits are provided for the replacement of each type of prosthetic device every five calendar years. Benefits for the purchase and repairs of prosthetic devices is limited to $10,000 per lifetime.	***Out-of-Area*** No	15%	Yes	Yes
20. Reconstructive Procedures Reconstructive procedures - services are considered reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part. By improving or restoring physiologic function it is meant that the target organ or body part is made to work better.	***PPO Network*** Yes	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.		

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
An example of a reconstructive procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.				
Cosmetic Procedures - services are considered Cosmetic Procedures when they improve appearance without making an organ or body part work better. The fact that a person may suffer psychological consequences from the impairment does not classify surgery and other procedures done to relieve such consequences as a reconstructive procedure. Reshaping a nose with a prominent "bump" would be a good example of a Cosmetic Procedure because appearance would be improved, but there would be no effect on function like breathing. This Plan does not provide Benefits for Cosmetic Procedures.	***PPO Non-Network*** Yes	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.		
Some services are considered cosmetic in some circumstances and reconstructive in others. This means that there may be situations in which the primary purpose of the service is to make a body part work better, whereas in other situations, the purpose would be to improve appearance and function (such as vision) is not affected. A good example is upper eyelid surgery. At times, this procedure will improve vision, while on other occasions improvement in appearance is the primary purpose of the procedure.	***Out-of-Area*** Yes	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.		
Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Other services mandated by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any				

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Covered Health Service. You can contact Care Coordination℠ at the toll free telephone number shown on your ID card, 1-866-249-7606, for more information about Benefits for mastectomy-related services. **Notify Care Coordination℠** Please remember that you should 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.				
21. Rehabilitation Services - Outpatient Therapy Short-term outpatient rehabilitation services for: • Physical therapy. • Occupational therapy. • Speech therapy. • Pulmonary rehabilitation therapy. • Cardiac rehabilitation therapy. Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment.	***PPO Network*** No	15%	Yes	Yes
	PPO Non-Network No	40%	Yes	Yes
	Out-of-Area No	15%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Please note that we will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly. Please note that the Plan excludes any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring. Any combination of PPO Network and PPO Non-Network Benefits is limited as follows: • 30 visits of physical therapy per calendar year. • 30 visits of occupational therapy per calendar year. • 30 visits of speech therapy per calendar year. • 20 visits of pulmonary rehabilitation therapy per calendar year. • 20 visits of cardiac rehabilitation therapy per calendar year. Out-of Area Benefits are limited as follows: • 30 visits of physical therapy per calendar year. • 30 visits of occupational therapy per calendar year. • 30 visits of speech therapy per calendar year. • 20 visits of pulmonary rehabilitation therapy per calendar year. • 20 visits of cardiac rehabilitation therapy per calendar year.				

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
22. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). Any combination of PPO Network and PPO Non-Network Benefits is limited to 60 days per calendar year. Out-of-Area Benefits are limited to 60 days per calendar year. Please note that, in general, the intent of skilled nursing is to provide Benefits for Covered Persons who are convalescing from an Injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation and facility services which are less than those of a general acute Hospital but greater than those available in the home setting. The Covered Person is expected to improve to a predictable level of recovery. Benefits are available when skilled nursing and/or rehabilitation services are needed on a daily basis. Accordingly, Benefits are NOT available when these services are required intermittently (such as physical therapy three times a week).	***PPO Network*** Yes	15%	Yes	Yes
	PPO Non-Network Yes	40%	Yes	Yes
	Out-of-Area Yes	15%	Yes	Yes

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Benefits are NOT available for custodial, domiciliary or maintenance care (including administration of enteral feeds) which, even if it is ordered by a Physician, is primarily for the purpose of meeting personal needs of the Covered Person or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence. (Custodial, domiciliary or maintenance care may be provided by persons without special skill or training. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, eating and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs.)				

Notify Care Coordination℠

Please remember that you must notify Care Coordination℠ as follows:

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

If you don't notify Care Coordination℠, Benefits will be reduced to 40% of Eligible Expenses.

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
23. Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy	***PPO Network*** No	15%	Yes	Yes
Benefits for Spinal Treatment include chiropractic and osteopathic manipulative therapy. Benefits for Spinal Treatment when provided by a Spinal Treatment provider in the provider's office.				
Benefits include diagnosis and related services and are limited to one visit and treatment per day.	***PPO Non-Network*** No	40%	Yes	Yes
Please note that the Plan excludes any type of therapy, service or supply including, but not limited to spinal manipulations by a chiropractor or other doctor for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.	***Out-of-Area*** No	15%	Yes	Yes
Any combination of Network and PPO Non-Network Benefits for Spinal Treatment is limited to 20 visits per calendar year.				
Out-of-Area Benefits for Spinal Treatment is limited to 20 visits per calendar year.				
24. Transplantation Services	***PPO Network*** Yes	15%	Yes	Yes
Covered Health Services for organ and tissue transplants when ordered by a Physician.				
Benefits are available for transplants when the transplant meets the				

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
definition of a Covered Health Service, and is not an Experimental or Investigational Service or an Unproven Service.				
Care Coordination℠ notification is required for all transplant services.	***PPO Non-Network***			
The service described under Transportation and Lodging below are Covered Health Services **ONLY** in connection with a transplant received at a Designated United Resource Network Facility.	Yes	40%	Yes	Yes
• Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. The search for bone marrow/stem cell from a donor who is not biologically related to the patient is a Covered Health Service only for a transplant received at a Designated United Resource Network Facility. If a separate charge is made for bone marrow/stem cell search, a Maximum Benefit of $25,000 is payable for all charges made in connection with the search. • Heart transplants. • Heart/lung transplants. • Lung transplants. • Kidney transplants. • Kidney/pancreas transplants. • Liver transplants. • Liver/small bowel transplants. • Pancreas transplants.	***Out-of-Area*** Yes	15%	Yes	Yes

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

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

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

Under the Plan there are specific guidelines regarding Benefits for transplant services. Contact Care Coordination℠ at the toll free telephone number, 1-866-249-7606, shown on your ID card for information about these guidelines.

Transportation and Lodging

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

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
procedure or necessary post-discharge follow-up. • Eligible Expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 for two people. • Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Designated United Resource Network Facility. • If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the $100 per diem rate. There is a combined overall lifetime maximum Benefit of $10,000 per Covered Person for all transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures. **Notify Care Coordination℠** You must notify Care Coordination℠ as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't notify Care Coordination℠, Benefits will be reduced to 40% of Eligible Expenses.				

Description of Covered Health Service	Must You Notify Care Coordination℠ ?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
25. Urgent Care Center Services Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this section.	***PPO Network***			
	No	15%	Yes	Yes
	PPO Non-Network			
	No	40%	Yes	Yes
	Out-of-Area			
	No	15%	Yes	Yes

Section 2: What's Not Covered--Exclusions

This section contains information about:

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

How We Use Headings in this Section

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

Plan Exclusions

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

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

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

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

A. Alternative Treatments

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

B. Comfort or Convenience

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

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

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

C. Dental

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

D. Drugs

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

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

4. Over the counter drugs and treatments.

E. Experimental or Investigational Services or Unproven Services

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

F. Foot Care

1. Except when needed for severe systemic disease:
   - Routine foot care (including the cutting or removal of corns and calluses).
   - Nail trimming, cutting, or debriding.
2. Hygienic and preventive maintenance foot care. Examples include the following:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.
   - Other services that are performed when there is not a localized illness, Injury or symptom involving the foot.
3. Treatment of flat feet.
4. Treatment of subluxation of the foot.
5. Shoe orthotics.

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

G. Medical Supplies and Appliances

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

H. Mental Health/Substance Abuse

1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
2. Services for Mental Health and Substance Abuse that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention.
3. Treatment for insomnia and other sleep disorders, dementia, neurological disorders and other disorders with a known physical basis.
4. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or

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

management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.

5. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
6. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee.
7. Residential treatment services.
8. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following:
   - Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
   - Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
   - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
   - Not consistent with the Mental Health/Substance Abuse Designee's guidelines or best practices as modified from time to time.

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

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

10. Treatment provided in connection with tobacco dependency.
11. Routine use of psychological testing without specific authorization.

I. Nutrition

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

J. Physical Appearance

1. Cosmetic Procedures. See the definition in Section 10: Glossary of Defined Terms. Examples include:
   - Pharmacological regimens, nutritional procedures or treatments.
   - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - Skin abrasion procedures performed as a treatment for acne.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.
   Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 1: What's Covered--Benefits.
3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
5. Wigs regardless of the reason for the hair loss.

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

K. Providers

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

   This exclusion does not apply to mammography testing.

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

L. Reproduction

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

M. Services Provided under Another Plan

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

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

N. Transplants

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

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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, unless determined by Care Coordination to be a proven procedure for the involved diagnoses under the heading *Transplantation Health Services* in Section 1: What's Covered--Benefits.

O. Travel

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

P. Vision (see separate Vision Benefit)

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

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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2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
   - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders.
   - Conducted for purposes of medical research.
   - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
4. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
6. In the event that a Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments and/or Annual Deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered to be medical or dental in nature, including oral appliances.
9. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly.
10. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.

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11. Non-surgical treatment of obesity, including morbid obesity.
12. Surgical treatment of obesity excluding severe morbid obesity (with a BMI greater than 35).
13. Growth hormone therapy.
14. Sex transformation operations.
15. Custodial Care.
16. Domiciliary care.
17. Private duty nursing.
18. Respite care.
19. Rest cures.
20. Psychosurgery.
21. Treatment of benign gynecomastia (abnormal breast enlargement in males).
22. Medical and surgical treatment of excessive sweating (hyperhidrosis).
23. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
24. Appliances for snoring.
25. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
26. Any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply or equipment.
27. Any charge for services, supplies or equipment advertised by the provider as free.
28. Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency.

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29. Any charges prohibited by federal anti-kickback or self-referral statutes.
30. Any additional charges submitted after payment has been made and your account balance is zero.
31. Any outpatient facility charge in excess of payable amounts under Medicare.
32. Any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services.
33. Outpatient rehabilitation services, Spinal Treatment or supplies including, but not limited to spinal manipulations by a chiropractor or other doctor, for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.
34. Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness, such as asthma or allergies.
35. Speech therapy to treat stuttering, stammering, or other articulation disorders.

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Section 3: Obtaining Benefits

This section includes information about:

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

Benefits for Covered Health Services

For the PPO Plan, Network Benefits are generally paid at a higher level than Non-Network Benefits. Network Benefits are payable for Covered Health Services which are any of the following:

- Provided by a Network Physician or other Network provider.
- Emergency Health Services.
- Covered Health Services that are described as Network Benefits in Section 1: What's Covered--Benefits.

Please note that Mental Health and Substance Abuse Services must be authorized by the Mental Health/Substance Abuse Designee. Please see Section 1: What's Covered--Benefits under the heading for *Mental Health and Substance Abuse*.

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The following compares Network and Non-Network Benefits.

Comparison of Network and Non-Network Benefits

	Network	Non-Network
Benefits	A higher level of Benefits means less cost to you. See Section 1: What's Covered--Benefits.	A lower level of Benefits means more cost to you. See Section 1: What's Covered--Benefits.
Who Should Notify Care Coordination℠	Notify *Care Coordination℠* for certain Covered Health Services. Failure to notify will result in reduced Benefits or no Benefits. See *Must You Notify Care Coordination℠?* column in Section 1.	
Who Should File Claims	Not required. The Claims Administrator pays Network providers directly.	You must file claims. See Section 5: How to File a Claim.
Outpatient Emergency Health Services	Emergency Health Services are always paid as a Network Benefit and are 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 meet the Annual Deductible or pay any difference between Eligible Expenses and the amount billed by the provider.	

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If you *are in the Out-of-Area Plan:*

Benefits are payable for Covered Health Services that are provided by or under the direction of a Physician or other provider and are generally paid at the in-network benefit level even if the provider is not in the network.

Whenever possible, however, you are encouraged to use in-network-providers. The cost of such services will be lower than for out-of-network providers. Therefore, your co-payment, which is a percentage of covered (eligible) charges, will be lower as well.

Provider Network

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

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

Separately, you will automatically be given a directory of Network providers at no cost to you. 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 PPO Network Benefits.

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

Designated United Resource Network Facilities and Other Providers

If you have a medical condition that Care Coordination^{SM} believes needs special services, they may direct you to a Designated United Resource Network Facility or other provider chosen by them. If you require certain complex Covered Health Services for which expertise is limited, Care Coordination^{SM} may direct you to a non-Network facility or provider.

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

PPO Non-Network Benefits

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

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Your Responsibility for Notification

You must notify Care Coordination℠ before getting certain Covered Health Services from Network, non-Network and Out-of-Area providers. The details are shown in the *Must You Notify Care Coordination℠?* column in Section 1: What's Covered--Benefits. If you fail to notify Care Coordination℠, Benefits are reduced or denied.

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

Care Coordination℠

When you notify Care Coordination℠ as described above, they will work with you to implement the Care Coordination℠ 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.

PPO Plan and Out-of-Area 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.

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

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

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Section 4: When Coverage Begins

This section includes information about:

- 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 your Employer 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.

You should notify the Claims Administrator within 48 hours of the day your coverage begins, or as soon as is reasonably possible. PPO 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
Eligible Person	Eligible Person usually refers to an Employee employed by a SPONSORING EMPLOYER who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as an Employee. For a complete definition of Eligible Person and Employee, see Section 10: Glossary of Defined Terms. If both spouses are Eligible Persons, each may enroll as an Employee or be covered as an Enrolled Dependent of the other, but not both. Except as we have described in Section 4: When Coverage Begins, Eligible Persons may not enroll without our written permission.	We determine who is eligible to enroll under the Plan.
Dependent	Dependent generally refers to the Employee'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. Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan. If both parents of a Dependent child are enrolled as an Employee, only one parent may enroll the child as a Dependent.	We determine who qualifies as a Dependent.

When to Enroll and When Coverage Begins

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

When to Enroll	Who Can Enroll	Begin Date
Adding New Dependents	Employees may enroll Dependents who join their family because of any of the following events: • Birth. • Legal adoption. • Placement for adoption. • Marriage. • Legal guardianship. • Court or administrative order.	Coverage begins on the date of the event if the Plan Administrator received the completed enrollment form and any required contribution for coverage within 31 days of the event that makes the new Dependent eligible.
Special Enrollment Period An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because required contributions were not paid on a timely basis.	A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs: • Birth. • Legal adoption. • Placement for adoption. • Marriage. A special enrollment period applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true: • The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and • Coverage under the prior plan ended because of any of the following: — Loss of eligibility (including, without	**Event Takes Place** (for example, a birth or marriage). 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.** Coverage begins on the day immediately following the day coverage under the prior plan ends if the Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the date coverage under the prior plan ended.

When to Enroll	Who Can Enroll	Begin Date
	limitation, legal separation, divorce or death). — The employer stopped paying the contributions. — In the case of COBRA continuation coverage, the coverage ended.	

Section 5: How to File a Claim

This section provides you with information about:

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

If You Receive Covered Health Services from a Network Provider

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

Filing a Claim for Benefits

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

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

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

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

Required Information

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

A. Employee's name and address.
B. The patient's name, age and relationship to the Employee.
C. The member number stated on your ID card.
D. An itemized bill from your provider that includes the following:

- Patient Diagnosis
- Date(s) of service
- Procedure Code(s) and descriptions of service(s) rendered
- Charge for each service rendered

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- Provider of service Name, Address and Tax Identification Number

E. The date the Injury or Sickness began.

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

Payment of Benefits

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

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

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

Benefit Determinations

Post-Service Claims

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

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45 day time frame and the claim is denied, the Claims Administrator

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will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45 day period, your claim will be denied.

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

Pre-Service Claims

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

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Urgent Claims that Require Immediate Action

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

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

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

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

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

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

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Concurrent Care Claims

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

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

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Section 6: Questions and Appeals

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

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

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

What to Do First

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

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

The Customer Service toll free telephone number, 1-866-249-7606, shown on your ID card. Customer Service representatives are available to take your call during regular business hours, Monday through Friday.

How to Appeal a Claim Decision

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

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

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

Appeal Process

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

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Administrator (first level appeals) and the Plan Administrator (second level appeals) may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeals Determinations

Pre-Service and Post-Service Claim Appeals

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

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

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

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

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level

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appeal from us as the Plan Administrator. Your second level appeal request must be submitted to us in writing within 60 days from receipt of the first level appeal decision.

The Plan Administrator has the exclusive right to interpret and administer the Plan, and these decisions are conclusive and binding.

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

Urgent Claim Appeals that Require Immediate Action

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

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

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

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Voluntary External Review Program

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

- Clinical reasons.
- The exclusion for Experimental, Investigational or Unproven Services.

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

Contact the Claims Administrator at the toll free telephone number, 1-866-249-7606, shown on your ID card for more information on the voluntary external review program.

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Section 7: Coordination of Benefits

This section provides you with information about:

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

Benefits When You Have Coverage under More than One Plan

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

When Coordination of Benefits Applies

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

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

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

Definitions

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

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

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

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

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

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

   a. If a Covered Person is confined in a private Hospital room, the difference between the cost of a Semi-private Room in the Hospital and the private room, (unless the patient's stay in a private Hospital room is medically necessary in terms of generally accepted medical practice, or one of the Coverage Plans routinely provides coverage for Hospital private rooms) is not an Allowable Expense.

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

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

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

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

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

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

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

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Order of Benefit Determination Rules

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

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

B. A Coverage Plan that does not contain a coordination of Benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of Benefits may provide that the supplementary coverage shall be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan Hospital and surgical Benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide PPO Non-Network Benefits.

C. A Coverage Plan may consider the Benefits paid or provided by another Coverage Plan in determining its Benefits only when it is secondary to that other Coverage Plan.

D. The first of the following rules that describes which Coverage Plan pays its Benefits before another Coverage Plan is the rule to use.

1. Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a Dependent, for example as an employee, member, subscriber or retiree is primary and the Coverage Plan that covers the person as a Dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage Plan covering the person as a Dependent; and primary to the Coverage Plan covering the person as other than a Dependent (e.g. a retired employee); then the order of

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Benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Coverage Plan is primary.

2. Child Covered Under More Than One Coverage Plan. The order of Benefits when a child is covered by more than one Coverage Plan is:

a. The Primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:

1) The parents are married;

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

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

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

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

c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of Benefits is:

1) The Coverage Plan of the custodial parent;

2) The Coverage Plan of the spouse of the custodial parent;

3) The Coverage Plan of the noncustodial parent; and then

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4) The Coverage Plan of the spouse of the noncustodial parent.

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

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Coverage Plan will not pay more than it would have paid had it been primary.

Effect on the Benefits of this Plan

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

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

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

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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.

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

Right to Receive and Release Needed Information

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

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

Payments Made

A payment made under another Coverage Plan may include an amount that should have been paid under this Coverage Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Coverage Plan. We will not have to pay that amount again. The term "payment made" includes providing Benefits in the form of services, in which case "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 we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the Benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

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Section 8: When Coverage Ends

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

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

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General Information about When Coverage Ends

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

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

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

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

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Events Ending Your Coverage

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

Ending Event	What Happens
The Entire Plan Ends	Your coverage ends on the date the Plan ends. We are responsible for notifying you that your coverage has ended.
You Are No Longer Eligible	Unless an exception applies, your coverage ends on the date you are no longer eligible to be an Employee or Enrolled Dependent. Please refer to Section 10: Glossary of Defined Terms for a more complete definition of the terms "Eligible Person," "Employee," "Dependent," and "Enrolled Dependent." You may qualify for continuation coverage under federal law. See page 67. Exceptions under which your coverage may extend beyond employment include: ▪ Layoff. If you are laid off as a result of a reduction of force or you voluntarily terminate employment pursuant to a voluntary reduction of force, coverage for you and your Dependents may be continued provided all required contributions are paid. During the first year, contributions are the same as required of an Active Employee. During the second year, you must pay 50% of the COBRA rate (see below). During the third year and thereafter, you must pay 100% of the COBRA rate. This period of coverage will be credited toward satisfying the maximum coverage provided under COBRA as discussed below. ▪ Disability. If you become disabled and qualify for disability benefits under your Employer's short-term or long-term disability program (or state industrial insurance), coverage for you and your Eligible Dependents may be continued for the duration of the disability, until a dependent no longer qualifies as such, or until you are eligible for normal retirement, whichever first occurs. You must pay all required contributions. This period of coverage will be credited toward satisfying the maximum coverage provided under COBRA as discussed below. ▪ Death. If you die, coverage for your Eligible Dependents will continue for a period of one year. Coverage is dependent upon paying the required contributions. Coverage ends upon the earlier of failure to make the required contributions or remarriage of a spouse. Remarriage of a spouse does not render other Dependents ineligible. Dependent Coverage will end when the dependent no longer

Ending Event	What Happens
	meets the eligibility criteria to qualify as a Dependent. This period of coverage will be credited toward satisfying the maximum coverage provided under COBRA discussed below. ▪ Strike. If you cease work because of a strike, lockout, suspension or other labor dispute, coverage can be continued for up to six months. Coverage will end upon failure to make required contributions. This coverage will be credited toward satisfying the maximum coverage provided under COBRA as discussed below. In addition to the foregoing, coverage for you and your dependents may be continued while you are on an approved leave of absence (other than for military service) provided all required contributions are paid. Coverage may be continued during family and medical leave or military leave as follows: ▪ Family and Medical Leave. If you are on an unpaid leave to care for a newborn; to care for a child placed with you for adoption or foster care; of for your serious health condition of that of your spouse, child or parent, coverage for you and your Eligible Dependents will be continued for up to 12 weeks. Your Employer will continue to pay for the coverage to the extent required by law. To maintain you eligibility, you must continue to contribute the same share of the cost of coverage that you would pay when not on leave. ▪ Military Leave. You may continue your coverage if you go into military service to the extent mandated by the Uniformed Services and Reemployment Rights Act of 1994. You and your Dependents must be covered at the time you leave for military service. The maximum period of coverage is the lesser of: o The 18-month period beginning on the date that uniformed service leave commences. o The period beginning on the date that uniformed service leave commences and ending on the day after the day on which you were required to apply for a return to a position of employment and failed to do so. You may be required to pay up to 102% of the full contribution required of an active employee except when you are on active duty for 30 days or less, in which case the cost you must bear cannot exceed an Active Employee's share. On your return, Plan exclusions and waiting periods may be imposed for any sickness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or

Ending Event	What Happens
	aggravated during, military service.
The Claims Administrator Receives Notice to End Coverage	Your coverage ends on the date the Claims Administrator receives written notice from us (i.e., the HEWT or your employer), instructing the Claims Administrator to end your coverage, or the date requested in the notice, if later.
Employee Retires or Is Pensioned	Your coverage ends on the date that you retire from active employment with a Sponsoring Employer. However, you may qualify for continuation coverage under federal law. See page 66. In addition, you may qualify for health coverage in retirement under the Hanford Employee Welfare Trust Retiree Medical Plan. For information on the eligibility requirements, go to the "Plan Document and Administrative Information – Hanford Retiree Welfare Benefit Plans.

Other Events Ending Your Coverage

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

Ending Event	What Happens
Fraud, Misrepresentation or False Information	Fraud or misrepresentation, or because the Employee knowingly gave us or the Claims Administrator false material information. Examples include false information relating to another person's eligibility or status as a Dependent. During the first two years the Plan is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Plan. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.
Material Violation	There was a material violation of the terms of the Plan.
Improper Use of ID Card	You permitted an unauthorized person to use your ID card, or you used another person's card.
Failure to Pay	You failed to pay a required contribution.
Threatening Behavior	You committed acts of physical or verbal abuse that pose a threat to our staff, the Claims Administrator's staff, a provider, or other Covered Persons.

Coverage for a Handicapped Child

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

- Before reaching age 23.
- Is not able to be self-supporting because of mental retardation or physical handicap.
- Depends mainly on the Employee for support.

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

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

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

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

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Continuation of Coverage

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

Continuation Coverage under 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:

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

Qualifying Events for Continuation Coverage under COBRA

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

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A. Termination of the Employee from employment with us, for any reason other than gross misconduct, or reduction of hours; or
B. Death of the Employee; or
C. Divorce or legal separation of the Employee; or
D. Loss of eligibility by an Enrolled Dependent who is a child; or
E. Entitlement of the Employee to Medicare Benefits; or
F. Your Sponsoring Employer filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Employee and his or her Enrolled Dependents. This is also a qualifying event for any retired Employee and his or her Enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

Notification Requirements and Election Period for Continuation Coverage under COBRA

The Employee or other Qualified Beneficiary must notify the Plan Administrator within 60 days of the Employee's divorce, legal separation or an Enrolled Dependent's loss of eligibility as an Enrolled Dependent. If the Employee 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 an Employee is continuing coverage under Federal Law, the Employee must notify the Plan Administrator within 60 days of the birth or adoption of a child.

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

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If the Qualified Beneficiary's coverage was terminated due to a qualifying event, then the initial premium due to the Plan Administrator must be paid on or before the 45th day after electing continuation.

COBRA Terminating Events

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

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

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

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

C. For the Enrolled Dependents of an Employee who was entitled to Medicare prior to a qualifying event that was due to either the termination of employment or work hours being reduced, eighteen months from the date of the qualifying event, or, if later, 36 months from the date of the Employee's Medicare entitlement.

D. The date coverage terminates under the Plan for failure to make timely payment of the premium.

E. The date, after electing continuation coverage, that coverage is first obtained under any other group health Plan. If such coverage contains a limitation or exclusion with respect to any preexisting condition, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the pre-existing condition limitation or exclusion.

F. The date, after electing continuation coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event that coverage was terminated because the Plan Sponsor filed for bankruptcy, (i.e. qualifying event F.).

G. The date your Sponsoring Employer ceases to provide group health benefits to any Employees.

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

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If a Qualified Beneficiary is entitled to 18 months of continuation and a second qualifying event occurs during that time, the Qualified Beneficiary's coverage may be extended up to a maximum of 36 months from the date coverage ended because employment was terminated or hours were reduced. If the Qualified Beneficiary was entitled to continuation because the Sponsoring Employer filed for bankruptcy, (i.e. qualifying event F.) and the retired Employee dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for 36 months from the date of the Employee's death. Terminating events B through G described in this section will apply during the extended continuation period.

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

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Section 9: General Legal Provisions

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

Plan Document

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

Relationship with Providers

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

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

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

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

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

Your Relationship with Providers

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

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

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

Incentives to Providers

The Claims Administrator pays Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost

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efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

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

The methods used to pay specific Network providers may vary. From time to time, the payment method may change. If you have questions about whether your Network provider's contract includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact the Claims Administrator at the telephone number, 1-866-249-7606, shown on your ID card. They can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

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

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Interpretation of Benefits

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

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

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

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

Administrative Services

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

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Amendments to the Plan

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

Any provision of the Plan which, on its effective date, is in conflict with the requirements of federal statutes or regulations, or applicable state law provisions not otherwise preempted by ERISA (of the jurisdiction in which the Plan is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

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

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to Benefits. These errors include, but are not limited to, providing misinformation on eligibility or Benefit coverages or entitlements. 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.

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

Information and Records

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

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

We and the Claims Administrator have the right to release any and all records concerning health care services 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.

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

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.

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

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

If you are enrolled in a Medicare+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

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. If you receive a Benefit payment from the Plan for an Injury caused by a third party, and you later receive any payment for that same condition or Injury from another person, organization or insurance company, we have the right to recover any payments made by the Plan to you. This process of recovering earlier payments is called subrogation. In case of subrogation, you may be asked to sign and deliver information or documents necessary for us to protect our right to recover Benefit payments made. You agree to provide us all assistance necessary as a condition of participation in the Plan, including cooperation and information submitted to as supplied by a workers' compensation, liability insurance carrier, and any medical Benefits, no-fault insurance, or school insurance coverage that are paid or payable.

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

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

You agree as follows:

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

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Refund of Overpayments

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

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

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

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

Limitation of Action

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

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

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Section 10: Glossary of Defined Terms

This section:

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

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

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

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

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

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

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

Any amount you pay for medical expenses in the last three months of the previous calendar year, that is applied to the previous Annual Deductible, will be carried over and applied to the current Annual Deductible. This carry-over feature applies only to the individual Annual Deductible.

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

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

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

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

Continuous Creditable Coverage - health care coverage under any of the types of plans listed below, during which there was a break in coverage of no more than 62 days:

- A group health plan.
- Health insurance coverage.
- Medicare.
- Medicaid.

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- Medical and dental care for members and certain former members of the uniformed services, and for their dependents.
- A medical care program of the Indian Health Services Program or a tribal organization.
- A state health benefits risk pool.
- The Federal Employees Health Benefits Program.
- Any public health benefit program provided by a state, county, or other political subdivision of a state.
- A health benefit plan under the Peace Corps Act.

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.

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

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by Care Coordination℠ on our behalf.

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

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

Covered Health Services must be provided:

- When the Plan is in effect;

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

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

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

Custodial Care - services that:

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

Dependent - the Employee's legal spouse or an unmarried Dependent child of the Employee or the Employee's spouse. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.

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- A child for whom legal guardianship has been awarded to the Employee or the Employee's spouse.

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

- A Dependent includes an unmarried Dependent child who is 23 years of age or older, only if you furnish evidence upon our request, satisfactory to us, of all the following conditions:
  - The child must not be regularly employed on a full-time basis.
  - The child must be a Full-time Student.
  - The child must be primarily Dependent upon the Employee for support and maintenance.

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

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

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

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

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

fact that a Hospital is a Network Hospital does not mean that it is a Designated United Resource Network Facility.

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

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

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

Eligible Expenses are based on either of the following:

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

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

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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.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

Eligible Person - a regular full-time Employee of the Plan Sponsor who is scheduled to work at his or her job at least 30 hours per week. A regular part-time Employee of the Plan Sponsor who is scheduled to work at his or her job at least 20 hours per week.

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.

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

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

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

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

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

Full-time Student - a person who is enrolled in and attending, full-time, a recognized course of study or training at one of the following:

- An accredited high school.
- An accredited college or university.

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- A licensed vocational school, technical school, beautician school automotive school or similar training school.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. You are no longer a Full-time Student on the date you graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

You continue to be a Full-time Student during periods of regular vacation established by the institution. If you do not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end as described above.

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

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

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

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

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

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

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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.

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

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

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

Mental Health/Substance Abuse Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Abuse Services for which Benefits are available under the Plan.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Plan.

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

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

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

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

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

Out of Area Benefits - applies ONLY to active employees (and their dependents) whose homes are NOT located in an areas in which UnitedHealthcare network providers are available.

Out-of-Pocket Maximum - the maximum amount of Copayments you pay every calendar year. If you use both PPO Network Benefits and PPO Non-Network Benefits, two separate Out-of-Pocket Maximums apply. Once you reach the Out-of-Pocket Maximum, Benefits for those Covered Health Services that apply to the Out-of-

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Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that calendar year.

Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum, as specified in Section 1: What's Covered--Benefits and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.

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

- Any charges for non-Covered Health Services.
- Copayments for Covered Health Services available by an optional Rider.
- Any Copayments for Covered Health Services in Section 1: What's Covered--Benefits that do not apply to the Out-of-Pocket Maximum.
- The Annual Deductible.
- The amount of any reduced Benefits if you don't notify Care Coordination℠ as described in Section 1: What's Covered--Benefits under the *Must You Notify Care Coordination℠*? column.
- Charges that exceed Eligible Expenses.
- Charges for Mental Health and Substance Abuse Services.

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

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

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- The amount of any reduced Benefits if you don't notify Care Coordination[SM] as described in Section 1: What's Covered--Benefits under the *Must You Notify Care Coordination[SM]*? column.
- Charges that exceed Eligible Expenses.

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

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

Plan - HEWT Options PPO and Out-of-Area Plan for Hanford Employee Welfare Trust Health Benefit Plan.

Plan Administrator - is the Hanford Employee Welfare Trust or its designee as that term is defined under ERISA.

Plan Sponsor - Hanford Employee Welfare Trust. References to "we", "us", and "our" throughout the SPD refer to the Plan Sponsor.

Preexisting Condition - an Injury or Sickness that is identified by the Plan Administrator as having been diagnosed or treated, or for which prescription medications or drugs were prescribed or taken within the six month period ending on the person's enrollment date. (The enrollment date is the date the person became covered under the Plan or, if earlier, the first day of any waiting period under the Plan.) A Preexisting Condition does not include Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information.

Pregnancy - includes all of the following:

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

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

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

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

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

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

Substance Abuse Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are

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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.

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

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

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

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

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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 and Attachments

Vision Care Rider

Attachment I--Women's Health and Cancer Rights Act of 1998

Attachment II--Summary Plan Description

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Hanford Employee Welfare Trust (HEWT)

Options PPO Plan

Vision Care Rider

Effective: January 1, 2003

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Vision Care Plan Rider

This Rider to the Summary Plan Description provides Benefits for vision care.

Benefits are provided for vision care at either a Spectera Network Provider or Spectera-approved laboratory.

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 the Summary Plan Description Section 10: Glossary of Defined Terms.

NOTE: The Coordination of Benefits provision Section 7: Coordination of Benefits in the Summary Plan Description does not apply to vision care covered through this Rider. Vision care Benefits will not be coordinated with those of any other health coverage plan.

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Introduction

Summary of Coverage

Spectera has an extensive nationwide network of doctors who provide quality eyecare and materials. This Plan is designed to provide for regular eye examinations and benefits toward vision care expenses including glasses or contact lenses.

How the Plan Works

When you are ready to obtain vision care services, call your Spectera participating doctor. If you need to locate a Spectera participating doctor, call Spectera (800) 839-3242 or visit our Web site at www.spectera.com.

When making an appointment, identify yourself as a Spectera member. The participating doctor will also need the covered member's Social Security number, and the covered member's group name. The participating doctor will contact Spectera to verify your eligibility and plan coverage. The participating doctor will also obtain authorization for services and materials. If you are not eligible, the Spectera doctor will notify you.

At your appointment, the participating doctor will provide an eye examination and determine if eyewear is necessary. If so, the participating doctor will coordinate the prescription with a Spectera-approved, contract laboratory. The participating doctor will itemize any non-covered charges and have you sign a form to document that you received services. Spectera will pay the participating doctor directly for covered services and materials.

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

You are responsible for paying the doctor any applicable copayment(s), and any additional costs resulting from cosmetic options, or non-covered services and materials you have selected. Selecting a participating doctor from Spectera's network assures direct payment to the doctor and guarantees quality services and materials.

Network Benefits

When using a Network Provider, enrolled participants and eligible dependents are eligible for the following.

Examination: 100% covered once every 12 months. A comprehensive vision examination is provided by a network optometrist or ophthalmologist after a $10 copay.

Eyewear: After the material copay, lenses are 100% covered every 12 months. After the material copay, frames within the Spectera selection or allowance are 100% covered every 24 months. The material copay is $10. This applies to the entire purchase, not the lens and frame individually.

Services From a Non-Participating Doctor

More than 90% of Spectera's patients receive services from participating doctors, although you may select any licensed vision care provider for services. Your reimbursement schedules does not guarantee full payment, nor can Spectera guarantee patient satisfaction, when services are obtained from a non-participating provider.

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

If you elect vision coverage and choose to use a non-Network Provider, you will be reimbursed **up to**:

Exam and Materials: $150.00

Follow these steps if you obtain services and/or materials from a non-participating provider:

- Pay the provider the full amount of the bill and request a copy of the bill that shows the amount of the eye examination, lens type, and frame.
- Send a copy of the itemized bill(s) to Spectera. The following information **must** also be included in your documentation.
- Member's name and mailing address;
- Member's Social Security number;
- Member's employer or group name; and
- Patient's name, relationship to member, and date of birth.

You may submit the information on a HCFA-1500 form or any generic insurance claim form that may be available from your non-participating provider upon request.

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Section 1: What's Covered -- Vision Care Benefits

Standard Eye Examination and Glasses

Eye examination:	Once each 12 months*
Spectacle Lenses:	Once each 12 months*
Frame:	Once each 24 months*

**from your last date of service*

Spectacle Lenses and Frames

Spectera covers a wide selection of frames, but not all frames will be covered in full. When a patient selects a frame that exceeds the plan's allowance, these additional charges are administered at controlled costs. Spectera also has controlled costs for cosmetic options, and these charges are typically less than usual and customary fees. Please consult your participating provider about lens options which may be cosmetic in nature, and may result in additional charges.

Elective or Medically Necessary contact lenses may be provided instead of glasses.

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

Lenses

If prescribed, a pair of single vision or standard multi-focal lenses.

Frames

Your choice from a wide selection of fashionable frames will be covered. If you select a frame from outside the Spectera Selection, you will be given a $50 wholesale frame allowance. At retail optical providers, you will be able to choose from a wide variety of Selection frames, or receive a discount off of already reduced prices.

Contact Lenses

In lieu of lenses and a frame, you may select contact lenses. Spectera offers a wide variety of Selection contact lenses from many leading manufacturers (over 85% of participants choose from the Spectera Selection). Four boxes (12 pairs) of covered disposables are included when obtained from a network provider. A $105 credit will be applied toward the evaluation, fitting, and purchase of Non-Selection contact lenses once every 12 months. Please note:: To receive the full $105 credit, you must receive your exam, fitting and evaluation at the same provider.

Patient Options

Standard scratch coating is offered at no additional cost to the participant. Should you choose patient options not covered by the program such as tints, progressive lenses, UV, and anti-reflective coating, you will be able to purchase these options at a significant discount. This additional benefit may save you 20% to 40% off of retail on cosmetic lens options and lens upgrades.

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

Laser Eye Surgery

Spectera participants receive access to discounted refractive eye surgery procedures from numerous provider locations throughout the United States. To find a participating Laser Eye Surgeon in your area, visit our web site at www.spectera.com.

Medically Necessary Contact Lenses:

Covered in full when prescribed by a participating doctor for one of the following conditions:

- Following cataract surgery.

Not Covered

- To correct extreme vision problems that cannot be corrected with spectacle lenses;
- With certain conditions of anisometropia; or
- With certain conditions of keratoconus.

The participating doctor must secure prior approval from Spectera for Medically Necessary contact lenses.

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

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Section 2: What's Not Covered -- Exclusions

This plan is designed to cover your visual needs rather than cosmetic materials. If you select any of the following, you will be responsible for an additional charge:

- Blended lenses;
- Oversize lenses;
- Progressive multifocal lenses;
- Photochromic or tinted lenses other than Pink 1 or 2;
- Coated or laminated lenses;
- A frame that exceeds the plan allowance;
- Certain limitations on low vision care;
- Cosmetic lenses;
- Optional cosmetic processes; or
- UV protected lenses.

The following professional services or materials are not covered. Discounts may apply to some items.

- Orthoptics or vision training and any associated supplemental testing;
- Plano lenses (non-prescription)
- Two pair of glasses in lieu of bifocals;

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

- Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment; or
- Corrective vision services, treatments, and materials of an experimental nature.

This is only a summary. For additional information, see your employer's benefits representative.

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

Section 3: Claims Administration

Filing Claims

Please mail the itemized bill(s) and claim form to the following address:

Spectera
Attention: Claims Department
2811 Lord Baltimore Drive
Baltimore, Maryland 21244-2644

Please note that claims for reimbursement must be filed within one year of the date services were completed.

If you need further information about your plan's reimbursement schedule, contact your employer.

Claim Review Procedure

If a claim for benefits is denied, a written request may be submitted to Spectera for a full review of the denial. This request must be made within 60 days of the denial. The exercise this option, call Spectera at 1-800-638-3120 to obtain details on procedures to follow.

- End of Vision Care Plan Rider -

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Attachment I-- Women's Health and Cancer Rights Act of 1998

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

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

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

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

Group health Plans and health insurance issuers generally may not, under Federal law, restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, Plans and issuers may not, under Federal law, require than a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

Attachment II -- Summary Plan Description

Summary Plan Description

Name of Plan: Hanford Employee Welfare Trust

Name of Employer sponsoring the Plan

A complete list of Employers sponsoring the Plan may be obtained by Participants and Beneficiaries upon written request to the Plan Administrator and is available for examination by Participants and Beneficiaries as required by Department of Labor Regulation Sections 2520.104b-1 and 2520.104b-30.

The following are Plan Sponsors as of January 1, 2003:

Bechtel Hanford, Inc. (BHI)

Energy Northwest

Fluor Hanford, Inc. (FH)

Johnson Controls, Inc. (JCI)

CH2MHILL Hanford Group, Inc. (CHG)

Numatec Hanford Corporation (NHC)

The Day and Zimmerman Group, Inc., Protection Technology Hanford

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CH2M HILL Hanford, Inc. (CHI)

Eberline Services Hanford, Inc.

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

Hanford Employee Welfare Trust
% Fluor Hanford, Inc.
P. O. Box 1000, MSIN H3-08
Richland, WA 99352
(509) 372-3323

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

Employer Identification Number (EIN): 33-0691003

IRS Plan Number: 550

Effective Date of Plan: January 1, 2003

Type of Plan: Group health care coverage plan

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

Hanford Employee Welfare Trust
% Fluor Hanford, Inc.
P. O. Box 1000, MSIN H3-08
Richland, WA 99352
(509) 372-3323

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

United HealthCare Insurance Company
P.O. Box 150450
450 Columbus Blvd.
Hartford, CT 06115-0450

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

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of Benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. The Plan Sponsor also has selected a Provider Network established by United HealthCare Insurance Company. The named fiduciary of Plan is Hanford Employee Welfare Trust, the Plan Sponsor.

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

Person designated as agent for service of legal process:

The name and address of the Agent for Service of Legal Process for the Plan is:

Ralph L. Hawkins
Davis Wright Tremaine LLP
1501 Fourth Avenue
2600 Century Square
Seattle, Washington 98101 – 1688

(206) 628-3150

Legal process may also be served upon a Plan Trustee or the Plan Administrator.

Source of contributions under the Plan: The sources of the contributions to the Plan are Employer and Employee contributions.

Method of calculating amount of contribution: Employee required contributions are determined by the Plan Sponsor. A schedule of such required contributions will be made available to eligible persons.

The Hanford Employee Welfare Trust is a funding medium through which benefits are provided.

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

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

Determinations of Qualified Medical Child Support Orders.

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

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

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

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

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

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

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

Receive Information About Your Plan and Benefits

The Plan is maintained pursuant to one or more collective bargaining agreements. A copy of such agreements may be obtained by Participants and Beneficiaries upon written request of the Plan Administrator and is available for examination by Participants and Beneficiaries as required by Department of Labor Regulation Sections 2520.104b-1 and 2520.104b-30.

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

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

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

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

Continue Group Health Plan Coverage

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

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you

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

from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

Assistance with Your Questions

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

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The benefits administered by United Healthcare end on page 101.

Please contact United Healthcare with any questions on these health benefits.

The pharmacy benefit program beginning on page 105 relates to coverage administered by Express Scripts.

Please contact Express Scripts with respect to these pharmacy benefits.

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Prescription Drugs

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Prescription Drug Benefits

Provided with the "OPTIONS PPO"
Medical Plan

Administered by Express Scripts, Inc.

Benefits in effect on January 1, 2003

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

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Prescription Drug Program (Active Employees)

The Options PPO includes a separate Pharmacy Benefit Program that is administered by Express Scripts rather than UnitedHealthcare

There are two ways you can purchase prescription drugs: from a participating retail pharmacy or by using mail order. This Prescription Program is briefly described below. Details of the program are available directly from Express Scripts.

YOUR SHARE OF THE COST (CO-PAYMENTS)

Both the mail and the retail programs have "two-tier" co-payment structures for active employees enrolled in the Options PPO Plan.

When you purchase a prescription, your cost will be the required co-payment (or you can pay the actual cost of the drug, if it is less than the applicable co-payment amount.) The co-payment depends on whether it is from retail or mail order. The two categories, or tiers, are:

GENERIC: Drugs in which the patent has expired, allowing other manufacturers to produce and distribute the product under a generic name. Generics are essentially a chemical copy of their brand-name equivalents. The color or shape may be different, but the active ingredients must be the same for both.

PREFERRED BRAND NAME: A drug with a trade name under which the product advertised and sold, and is protected by patents so that it can only be produced by one manufacturer for 7 years.

Your druggist can determine the category of a drug, or you can contact Express Scripts by calling their toll-free Customer Service

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line at 1-800-796-7518 . You can also contact them via the internet at www.express-scripts.com.

THE EXPRESS SCRIPTS-ADMINISTERED PRESCRIPTION PROGRAM INCLUDES THE FOLLOWING FEATURES:

- There is an annual maximum out-of-pocket limit of $1,500 per member/$2,500 per family. Both mail and retail co-payment amounts apply in the calculation.
- There is also a $50 per person/$150 per family annual deductible for *retail prescriptions*, only.
- However, there is no deductible applicable to prescriptions purchased by mail order.
- Co-payment amounts for both mail and retail prescription are subject to change based on costs and other factors.
- There are no replacement prescriptions allowable under the plan.
- Quantity limits may apply to some drugs. These are determined by the manufacturer and are subject to change.

Most prescription drugs are available to you under the Plan. They will be dispensed as written by the physician. However, you will pay more out-of-pocket if you request a brand-name drug when the prescription is written for a generic drug.

EXCLUSIONS - Drugs that are NOT covered by the plan include, but are not limited to, the following:

- multiple vitamins (including vitamins with fluoride)
- prenatal vitamins
- appetite suppressants

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- injectable drugs, except for ESI selected injectibles. (Contact Express Scripts for specific information)
- medications for cosmetic purposes (e.g. Rogaine)
- medications with no FDA indications (e.g. yohimbine)
- nystatin oral powder
- progesterone products (including compounded forms)
- over-the-counter (OTC) medications or products equivalent to OTC medications
- vitamin B12
- smoking deterrents
- anorexiants or other drugs used for weight control
- DESI drugs (drugs determined by the Food and Drug Administration to lack substantial evidence of effectiveness)
- drugs labeled "Caution - limited by federal law to investigational use" or experimental drugs
- therapeutic devices or appliances, support garments and other non-medical substances
- immunizing agents, biologicals, blood and blood plasma
- Accutane (Isotretinoin)

PRESCRIPTION DRUG REVIEW

Some prescription drugs require a "prescription drug review" or prior authorization before they may be covered by the Plan. If your pharmacist tells you that your prescription drug requires prior

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

authorization, ask your pharmacist or your doctor to call Express Scripts.

CUSTOMER SERVICE CENTER

The Express Scripts Customer Service Call Center is available 24 hours a day, 365 days a year to help you locate a participating pharmacy or help you better understand and use your program.

To reach the call center, call toll-free: 1-800-796-7518. (TDD for hearing impaired: * 1-800-899-2114, or 1-612-797- 4566).

In an emergency, a pharmacist can be reached 24 hours a day at 1-800-62-6080.

RETAIL PRESCRIPTION PROGRAM

Express Scripts offers retail prescription coverage through their "PerxCare" network which includes over 43,000 participating pharmacies nationwide. Check with your pharmacy to see if they are an Express Scripts participant or contact Express Scripts Customer Service for help in locating a participating pharmacy in your area.

YOUR COST

The Retail Prescription Program allows you to purchase up to a 34-day supply for a co-payment. Quantity limits may apply based on type of medication prescribed.

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

The following co-payments apply to prescriptions purchased from a participating retail pharmacy:

CATEGORY	CO-PAYMENT
Generic Drugs	$5.00
Brand Name	$15.00

PURCHASING PRESCRIPTIONS

AT A PARTICIPATING RETAIL PHARMACY:

When you purchase a prescription under this plan, you simply present your identification card (provided to you by Express Scripts). You will pay the amount needed to satisfy any unmet annual deductible plus the required co-payment amount. No claim forms are required after co-payment is made.

AT A RETAIL PHARMACY THAT IS NOT PARTICIPATING WITH EXPRESS SCRIPTS

You can also purchase a drug at a non-participating pharmacy. You should pay for the prescription, then submit a claim for reimbursement from Express Scripts.

However, if you purchase from a non-participating pharmacy, your reimbursement will be based on the Express Scripts in-network contracted rate for that drug. You will have to pay the difference between the

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

price charged by the non-network pharmacy and the Express Scripts contracted rate in addition to the applicable deductible and co-payment amounts.

For non-network retail purchases, complete an Express Scripts claim form and submit your claim and receipts to:

Express Scripts-WHC
P.O. Box 390873
Bloomington, MN 55439

Claim forms for out-of-network purchases can be requested from Express Scripts website, www.express-scripts.com, or by calling customer service at 1-800-796-7518.

MAIL ORDER DRUG PROGRAM

Another option for obtaining prescriptions is the Mail Order Drug Program, which allows you to purchase up to a 90-day supply of most prescription drugs for a single co-payment. The mail order pharmacy program is also administered by Express Scripts.

The Mail Order program works best for drugs that you take on a long-term basis ("maintenance drugs.") Most prescribed drugs and medicines are available to you under the Mail Order Drug Program (generic drugs are dispensed unless your physician directs otherwise). Certain drugs are not available by mail order. Contact Express Scripts Customer Service for more information.

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

YOUR COST

The following co-payments apply to prescriptions purchased from the Express Scripts Mail Order program:

CATEGORY	CO-PAYMENT
Generic Drugs	$9.00
Brand Name	$15.00

PURCHASING MAIL ORDER PRESCRIPTIONS

Ask your physician to prescribe needed medication for up to a 90-day supply plus refills. If you, or your eligible dependents, are presently taking medication, ask your doctor for a new prescription. Complete the patient profile questionnaire with your first order. Answer all questions and be sure to include your Social Security number on the form.

You can contact Express Scripts for the necessary mail order form and for other information.

Send the completed mail order form along with your prescription written for up to 90 days and your applicable co-payment. You can submit multiple prescriptions in one envelope; just be sure to include a co-payment for each prescription. Contact Customer Service to determine which category your prescription is: generic or brand-name.

Your prescriptions will be filled and returned to you at the address you have specified on your order form. If you need to change the address please call the 800 (toll-free) number listed on your order form, or you can change the address on the form itself.

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

Most prescription orders take 14 days to be filled and returned to you unless there are mail delays. If you need a supply of medication while waiting for your mail order prescription, ask your doctor for two prescriptions so you can get a small supply of medication from your local pharmacy while awaiting your Express Scripts prescription.

Once your Express Scripts Mail facility has processed your first prescription, you can order approved refills either by mail or on the internet at www.express-scripts.com.

Any time you have questions on your medication(s), you can call the Customer Service Department and talk to a pharmacist. Their toll-free number is: 1-800-796-7518

CLAIM AND APPEAL PROCEDURE

If you are not satisfied with the disposition of your claim for benefits under the Pharmacy Benefit Program, you have the right to appeal to the Plan Administrator. Your appeal should be filed with the Plan Administrator within 60 days of the denial of your claim by Express Scripts. For the Appeal Procedure see the Plan Document, Summary Plan Description and Administrative Information, Hanford Employee Welfare Benefit Plans (Administrative Wrapper). A copy of the Administrative Wrapper may be obtained without charge by contacting - Fluor Hanford Benefits Administration.

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