Benefits Handbook Date March 1, 2015

UnitedHealthcare Medical Plan Options

Marsh & McLennan Companies

UnitedHealthcare Medical Plan Options

Selecting a medical plan option for 2015 involves three key choices for eligible individuals.

- Select one of four medical plan options. A range of coverage levels and costs is offered.
- Select coverage for:
  - yourself only — Employee
  - yourself and your spouse or domestic partner — Employee + Spouse
  - yourself and your child or children — Employee + Child(ren)
  - yourself, your spouse or domestic partner, and children — Family
- Select your medical plan carrier:
  - All eligible individuals resident in any state except Hawaii may choose from among:
    - Aetna
    - Anthem BlueCross BlueShield (Anthem BCBS)
    - United Healthcare (UHC)

    Note: This section of the Benefits Handbook provides information about the UnitedHealthcare administered medical plan options only.

    Information about the Aetna and Anthem BlueCross BlueShiled administered medical plan options is covered in a separate section of the Benefits Handbook.
  - Eligible individuals resident in CA, CO, GA, MD, VA, OR, WA, and Washington DC have an additional choice to consider:
    - Kaiser Permanente (Kaiser)

    Information about the Kaiser administered medical plan options is covered in a separate section of the Benefits Handbook.

SPD and Plan Document

This section provides a summary of the Medical Plan (the "Plan") options available through UnitedHealthCare (UHC) as of January 1, 2015.

This section, together with the *Administrative Information* section and the applicable section about participation, forms the Summary Plan Description and plan document of the Plan.

- Eligible individuals who are resident in Hawaii, may only choose between:
  - HMSA's Health Plan Hawaii Plus HMO
  - HMSA's Preferred Provider Plan (PPP)

  Information about the Hawaii medical plan options is covered in a separate section of the Benefits Handbook.

All medical plan options described in this section of the Benefits Handbook offer:

- comprehensive health services
- the freedom to select between a health care provider that participates in your chosen medical plan carrier's network, generally at a lower cost to you, or a provider that does not participate in your chosen medical plan carrier's network, generally at a higher cost to you.

Note: Be sure to read about Health Care Flexible Spending Accounts (HCFSAs), Health Savings Accounts (HSAs) and Limited Purpose Health Care Flexible Spending Accounts (LPHCFSAs). Understanding these tax-advantaged arrangements may be important to your selection of a medical plan.

A Note about ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that governs many employer-sponsored plans including this medical plan. Your ERISA rights in connection with this Plan are detailed in the *Administrative Information* section.

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The Medical Plan Options at a Glance

The chart below outlines some important Plan features and coverage information that distinguish the four available UnitedHealthcare (UHC) medical plan options. Additional information is provided throughout this section of the Benefits Handbook including the "Detailed List of Covered Services" on page 45.

Plan feature	$350 Deductible Plan[1]	$800 Deductible Plan[1]	$1,500 Deductible Plan[1, 2, 3, 4]	$2,500 Deductible Plan[1, 2, 3, 4]
Deductible	***In-network:*** Employee: $350 Family: $700 ***Out-of-network:*** Employee: $2,000 Family: $4,000	***In-network:*** Employee: $800 Family: $1,600 ***Out-of-network:*** Employee: $2,400 Family: $4,800	***In-network:*** Employee: $1,500 Family: $3,000 ***Out-of-network:*** Employee: $3,000 Family: $6,000	***In-network:*** Employee: $2,500 Family: $5,000 ***Out-of-network:*** Employee: $4,500 Family: $9,000
Out-of-pocket maximum (including DEDUCTIBLE)	***In-network:*** Employee: $2,000 Family: $4,000 ***Out-of-network:*** Employee: $4,000 Family: $8,000	***In-network:*** Employee: $2,400 Family: $4,800 ***Out-of-network:*** Employee: $4,800 Family: $9,600	***In-network:*** Employee: $3,000 Family: $6,000 ***Out-of-network:*** Employee: $6,000 Family: $12,000	***In-network:*** Employee: $4,500 Family: $9,000 ***Out-of-network:*** Employee: $9,000 Family: $18,000
Coverage levels	***In-network:*** 80% after deductible ***Out-of-network:*** 60% after deductible (Out-of-network benefits are based on reasonable and customary charges)			***In-network:*** 70% after deductible ***Out-of-network:*** 50% after deductible (Out-of-network benefits are based on reasonable and customary charges)
Physician office visits				
Primary Care Physician	***In-network:*** *$15 per visit* ***Out-of-network:*** 60% of R&C after deductible Copay amounts do not apply to the deductible.	***In-network:*** 80% after deductible ***Out-of-network:*** 60% of R&C after deductible	***In-network:*** 80% after deductible ***Out-of-network:*** 60% of R&C after deductible	***In-network:*** 70% after deductible ***Out-of-network:*** 50% of R&C after deductible

Plan feature	$350 Deductible Plan[1]	$800 Deductible Plan[1]	$1,500 Deductible Plan[1, 2, 3, 4]	$2,500 Deductible Plan[1, 2, 3, 4]
Specialist	***In-network:*** *$30 per visit* ***Out-of-network:*** 60% of R&C after deductible Copay amounts do not apply to the deductible.	***In-network:*** 80% after deductible ***Out-of-network:*** 60% of R&C after deductible	***In-network:*** 80% after deductible ***Out-of-network:*** 60% of R&C after deductible	***In-network:*** 70% after deductible ***Out-of-network:*** 50% of R&C after deductible
Prescription drugs	There is a pharmacy network for retail and Express Scripts by Mail for mail order PRESCRIPTION DRUGS.			
Retail Prescriptions (30-day supply)				
▪ Generic	$10 (These amounts do not apply to the deductible)	70% (These amounts do not apply to the deductible; minimum $10/maximum $20)	80% after deductible	70% after deductible
▪ Formulary Brand	$30 (These amounts to do not apply to the deductible)	70% (These amounts do not apply to the deductible; minimum $25/maximum $50)	80% after deductible	70% after deductible
▪ Non-Formulary Brand	$60 (These amounts do not apply to the deductible)	55% (These amounts do not apply to the deductible; minimum $40/maximum $80)	80% after deductible	70% after deductible
Mail-order Prescriptions (90-day supply)				
▪ Generic	$25 (These amounts do not apply to the deductible)	70% (These amounts do not apply to the deductible; minimum $25/maximum $50)	80% after deductible	70% after deductible
▪ Formulary Brand	$75 (These amounts do not apply to the deductible)	70% (These amounts do not apply to the deductible; minimum $62.50/maximum $125)	80% after deductible	70% after deductible
▪ Non-Formulary Brand	$150 (These amounts do not apply to the deductible)	55% (These amounts do not apply to the deductible; minimum $100/maximum $200)	80% after deductible	70% after deductible

Plan feature	$350 Deductible Plan[1]	$800 Deductible Plan[1]	$1,500 Deductible Plan[1, 2, 3, 4]	$2,500 Deductible Plan[1, 2, 3, 4]
Contact Information for Carrier options:	Contact for Medical Service: UnitedHealthcare (Claims Administrator) P.O. Box 740800 Atlanta, GA 30374-0800 UnitedHealthcare Customer Service: +1 888 540 5954 Website: www.myuhc.com Contact for Prescription Service: Express Scripts (Pharmacy Benefits Manager) Phone: +1 800 987 8360 Website (for members): www.express-scripts.com Express Scripts Group #: MMCRX05 Marsh & McLennan Companies does not administer claims under this plan. For medical claims, the Claims Administrators' decisions are final and binding. For prescription drug claims, the Pharmacy Benefits Manager's decisions are final and binding.			

1 These plans are named for the deductible applicable to the "individual" for In-Network service providers. **Note:** The individual deductible is the amount each family member has to pay before the plan will reimburse any benefits. The deductibles applicable to any other coverage level (for example, "Family coverage") or for services provided by Out-of-Network service providers will be significantly higher than (in many instances, double) the amounts captured in the names of the plans.

2 These plans do not require that you or a covered dependent meet the "individual" deductible in order to satisfy the family deductible. If more than one person in a family is covered under the plan, the individual coverage deductible stated in the table above does not apply. Instead, the family deductible applies and no one in the family is eligible to receive benefits until the family deductible is satisfied.

3 Until you meet your deductible in the $1,500 Deductible Plan or $2,500 Deductible Plan, you can use your contributions to your Limited Purpose Health FSA to pay for only dental and vision expenses. Once you meet your deductible, you can use your contributions to pay for eligible medical expenses.

4 The $1,500 Deductible Plan and the $2,500 Deductible Plan meet the requirements for a high deductible health plan (HDHP). When you participate in either of these medical plan options, you are eligible to establish a tax-advantaged Health Savings Account (HSA) which you can use to help pay qualified health care expenses, including the deductible. For details about the Health Savings Account, see the Health Savings Account section.

Participating in the Plan

You are eligible to participate in the Plan if you meet the eligibility requirements described in the *Participating in Healthcare Benefits* section.

You have the option to cover your family members who meet the eligibility requirements that are described in the *Participating in Healthcare Benefits* section.

Retiree Eligibility

Certain retirees and their ELIGIBLE FAMILY MEMBERS that are not yet deemed to be eligible for MEDICARE may also be eligible for coverage under this plan. For information on the eligibility requirements, how to participate and the cost of coverage, see the *Participating in Pre-65 Retiree Medical Coverage* section.

Enrollment

To participate in this Plan, you must enroll for coverage. You may enroll only:

- within 30 days of the date you become eligible to participate
- during Annual Enrollment (generally in November with respect to coverage for the following calendar year)
- within 60 days of a qualifying change in family status that makes you eligible to enroll
- within 30 days of losing other coverage that you had relied upon when you waived your opportunity to enroll in this Plan.

Enrollment procedures for you and your ELIGIBLE FAMILY MEMBERS are described in the *Participating in Healthcare Benefits* section.

Cost of Coverage

You and the Company share the cost of coverage for both you and your ELIGIBLE FAMILY MEMBERS.

The cost of your coverage depends on the plan option and level of coverage you choose.

You can choose from four levels of coverage. Cost for each coverage level for eligible Marsh & McLennan Companies Employees (other than Marsh & McLennan Agency LLC – Southwest (including Prescott Pailet Benefits) (collectively MMA Southwest) (MMA-Southwest), Marsh & McLennan Agency LLC – Northeast (MMA-Northeast), or Security Insurance Services of Marsh & McLennan Agency) is shown below.

You pay the HealthyMe rate on your annual medical plan contributions, if you and your spouse/domestic partner both enroll in the Plan and if you and your spouse/domestic partner **both** completed the three Know Your Numbers steps within the designated required time period.

Note: Employees hired on or after July 1, 2014, will receive the 2015 HealthyMe rate even if they did not complete the three Know Your Numbers steps.

HealthyMe Rates	**$350 Deductible Plan**		**$800 Deductible Plan**		**$1,500 Deductible Plan**		**$2,500 Deductible Plan**	
Eligible Marsh & McLennan Companies Employees	***Semi-monthly cost***	***Weekly cost***	***Semi-monthly cost***	***Weekly cost***	***Semi-monthly cost***	***Weekly cost***	***Semi-monthly cost***	***Weekly cost***
Employee Only	$94.09	$43.42	$69.70	$32.17	$40.34	$18.62	$17.33	$8.00
Employee + Spouse	$235.08	$108.50	$176.77	$81.58	$106.74	$49.26	$51.08	$23.57
Employee + Child(ren)	$188.17	$86.85	$139.41	$64.34	$80.67	$37.23	$34.66	$16.00
Family	$338.58	$156.27	$253.44	$116.97	$151.10	$69.74	$70.14	$32.37

You pay the Blended rate on your annual medical plan contributions if you and your spouse/domestic partner enroll in the Plan **but only one of you** completed the three Know Your Numbers steps within the designated required time period.

Blended Rates	**$350 Deductible Plan**		**$800 Deductible Plan**		**$1,500 Deductible Plan**		**$2,500 Deductible Plan**	
Eligible Marsh & McLennan Companies Employees	***Semi-monthly cost***	***Weekly cost***	***Semi-monthly cost***	***Weekly cost***	***Semi-monthly cost***	***Weekly cost***	***Semi-monthly cost***	***Weekly cost***
Employee Only	$94.09	$43.42	$69.70	$32.17	$40.34	$18.62	$17.33	$8.00
Employee + Spouse	$260.08	$120.04	$201.77	$93.12	$131.74	$60.80	$76.08	$35.11
Employee + Child(ren)	$188.17	$86.85	$139.41	$64.34	$80.67	$37.23	$34.66	$16.00
Family	$363.58	$167.80	$278.44	$128.51	$176.10	$81.28	$95.14	$43.91

You pay the Standard rate on your annual medical plan contributions if you and your spouse/domestic partner enroll in the Plan **but neither you nor your spouse/domestic partner** completed the three Know Your Numbers steps within the designated required time period.

Standard Rates	**$350 Deductible Plan**		**$800 Deductible Plan**		**$1,500 Deductible Plan**		**$2,500 Deductible Plan**	
Eligible Marsh & McLennan Companies Employees	***Semi-monthly cost***	***Weekly cost***	***Semi-monthly cost***	***Weekly cost***	***Semi-monthly cost***	***Weekly cost***	***Semi-monthly cost***	***Weekly cost***
Employee Only	$119.09	$54.96	$94.70	$43.71	$65.34	$30.15	$42.33	$19.54
Employee + Spouse	$285.08	$131.58	$226.77	$104.66	$156.74	$72.34	$101.08	$46.65
Employee + Child(ren)	$213.17	$98.39	$164.41	$75.88	$105.67	$48.77	$59.66	$27.54
Family	$388.58	$179.34	$303.44	$140.05	$201.10	$92.82	$120.14	$55.45

Medical rates are not available for employees of MMA-Southwest, MMA-Northeast, or Security Insurance Services of Marsh & McLennan Agency. For contribution rates, contact the Employee Service Center at +1 866 374 2662, any business day, from 8:00 a.m. to 8:00 p.m. Eastern time.

See the *Participating in Healthcare Benefits* section for more information on the cost of your coverage, such as information about taxes.

Imputed Income for Domestic Partner Coverage

If you cover your domestic partner or your domestic partner's children, there may be imputed income for the value of the coverage for those family members. See the *Participating in Healthcare Benefits* section for more information on imputed income for domestic partner coverage.

The table below shows the imputed income amounts for all ELIGIBLE Marsh & McLennan Companies EMPLOYEES (including MMA-Southwest, MMA-Northeast, or Security Insurance Services of Marsh & McLennan Agency):

Section 152 Dependents

If your domestic partner (or his or her child(ren)) qualifies as a dependent under IRS Section 152, imputed income does not apply.

Imputed Income Rates								
Imputed Income for Domestic Partner Coverage	**$350 Deductible Plan**		**$800 Deductible Plan**		**$1,500 Deductible Plan**		**$2,500 Deductible Plan**	
Eligible Marsh & McLennan Companies Employees	***Semi-monthly cost***	***Weekly cost***	***Semi-monthly cost***	***Weekly cost***	***Semi-monthly cost***	***Weekly cost***	***Semi-monthly cost***	***Weekly cost***
Employee + Domestic Partner (non-qualified)	$380.60	$175.66	$355.86	$164.24	$323.96	$149.52	$282.54	$130.40
Employee + Child(ren) (non-qualified)	$271.86	$125.47	$254.19	$117.32	$231.40	$106.80	$201.81	$93.15
Employee + Domestic Partner (non-qualified) & Child(ren)	$407.79	$188.21	$381.27	$175.97	$347.10	$160.20	$302.72	$139.71
Employee + Domestic Partner & Child(ren) (Domestic Partner and Child(ren) (non-qualified)	$679.64	$313.68	$635.46	$293.29	$578.50	$267.00	$504.53	$232.86

ID Cards

If you are enrolled in employee only coverage you will automatically be sent one ID card for your medical coverage and one ID card for your prescription drug coverage. You will be sent one

additional ID card if you enroll five or more family members in the Plan. Each ID card will list the employee's name and the names of up to five covered family members.

You will be sent your ID card(s) within two to four weeks of your enrollment.

You may request additional ID cards directly from the Claims Administrator.

How the Medical Plan Options Work

All of the medical plan options help you and your family to pay for medical care. As a participant, you may choose, each time you need medical treatment, to use:

- Any physician, hospital or lab, or
- A provider who participates in the UnitedHealthCare Choice Plus network and has agreed to charge reduced fees to the Plan members. Using the network is more cost effective than using non-network providers because their fees are typically less than those charged by non-network providers.

If you use an in-network provider, you do not need to submit a claim form. IN-NETWORK PROVIDERS bill the Claims Administrator directly.

Under the $350 Deductible Plan

Generally, the Plan's reimbursement is 80% for in-network providers and 60% of reasonable and customary charges for OUT-OF-NETWORK PROVIDERS after the Plan's DEDUCTIBLE has been met. You pay the remainder of the fee. (There are some in-network services that don't apply to the deductible and only require copays).

Under the $800 Deductible Plan

Generally, the Plan's reimbursement is 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met. You pay the remainder of the fee.

Under the $1,500 Deductible Plan

Generally, the Plan's reimbursement is 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met. You pay the remainder of the fee.

Under the $2,500 Deductible Plan

Generally, the Plan's reimbursement is 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met. You pay the remainder of the fee.

See the "Detailed List of Covered Services" on page 45 for more detailed information.

Certain expenses are not covered or reimbursed by the Plan, such as any deductible you are required to meet and your share of the amounts above the reasonable and customary charge.

Some services have specific limits or restrictions; see individual service for more information.

Refer to the "What's Not Covered" on page 59 to find out about the services that are not covered under the Plan.

Benefits are only paid for MEDICALLY NECESSARY charges or for specified wellness care expenses.

Prior Authorization may be required in order to receive coverage for certain services. It is the Plan participant's responsibility (not the provider or facility) to obtain prior Authorization for out-of-network services. For more information on the prior Authorization process and applicable services, refer to the description under "Utilization Review" on page 17.

IMPORTANT

UnitedHealthcare Harvard Pilgrim Health Care and Medica have partnered to provide you with greater access to Network Providers. This SPD contains information about UnitedHealthcare, Harvard Pilgrim Health Care and Medica, including their networks and the claims administration services they provide. If you have any questions after reading this material, please call the Customer Service number on the back of your ID card.

In addition, there are two websites, www.myuhc.com and www.mymedica.com, which can be accessed by you to obtain benefit information, locate Network Providers, request ID Cards, and research health topics. Please access the website identified on the back of your ID card.

Health Savings Account and Flexible Spending Accounts

If you are a participant in the $350 DEDUCTIBLE Plan or $800 Deductible Plan, you can elect a Flexible Spending Account (FSA) that allows you to put aside money before taxes are withheld so that you can pay for eligible medical, dental and vision expenses that are not reimbursed by any other coverage that you and your qualifying family members have. If you elect the $1,500 Deductible Plan or the $2,500 Deductible Plan, you can elect to participate instead in a Health Savings Account (HSA) and, if you choose, a Limited Purpose Health Care Flexible Spending Account (LPHCFSA).

For details about the FSA, HSA, or the LPHCFSA, see the *Health Care Flexible Spending Account, Health Savings Account, or Limited Purpose Health Care Flexible Spending Account* sections.

Deductibles

The DEDUCTIBLE is the amount that must be paid before the Plan will reimburse any benefits.

The deductibles vary under each of the medical plan options available to you (as shown in the table below.

Plan feature	$350 Deductible Plan	$800 Deductible Plan	$1,500 Deductible Plan	$2,500 Deductible Plan
Deductible	***In-network:*** Employee: $350 Family: $700 ***Out-of-network:*** Employee: $2,000 Family: $4,000	***In-network:*** Employee: $800 Family: $1,600 ***Out-of-network:*** Employee: $2,400 Family: $4,800	***In-network:*** Employee: $1,500 Family: $3,000 ***Out-of-network:*** Employee: $3,000 Family: $6,000	***In-network:*** Employee: $2,500 Family: $5,000 ***Out-of-network:*** Employee: $4,500 Family: $9,000

Do in-network claims apply toward the out-of-network deductible?

No. Only out-of network claims apply toward the out-of-network deductible.

Do out-of-network claims apply toward the in-network deductible?

Yes. Out-of-network claims apply toward the in-network deductible. Also, in-network claims apply toward the in-network deductible.

How do deductibles work?

Under the $350 Deductible Plan

The Plan will begin reimbursing benefits for a covered family member (including a newborn) once he or she has met the individual deductible (even if the entire family deductible has not been met). The family deductible is the maximum amount you have to pay before the Plan will reimburse any benefits. Copays for doctor visits (including ER and urgent care) and PRESCRIPTION DRUGS do not count toward the deductibles for the $350 Deductible Plan.

Under the $800 Deductible Plan

The Plan will begin reimbursing benefits for a covered family member (including a newborn) once he or she has met the individual deductible (even if the entire family deductible has not been met). The family deductible is the maximum amount you have to pay before the Plan will reimburse any benefits. Prescription drugs do not count toward the deductibles for the $800 Deductible Plan.

Under the $1,500 Deductible Plan

If the “employee” coverage level is elected, the Plan will begin reimbursing benefits for the one covered individual once he or she has met the individual deductible. For any other coverage level (employee + spouse, employee + child(ren) or family, the Plan will begin reimbursing benefits for a covered family member (including a newborn) once the family deductible is met. In meeting your family deductible, each family member’s (including a newborn’s) covered expenses (medical and prescription drug expenses) count toward the family deductible. Once this family deductible is met, the Plan will pay benefits for all family members.

Under the $2,500 Deductible Plan

If the “employee” coverage level is elected, the Plan will begin reimbursing benefits for the one covered individual once he or she has met the individual deductible. For any other coverage level (employee + spouse, employee + child(ren) or family, the Plan will begin reimbursing benefits for a covered family member (including a newborn) once the family deductible is met. In meeting your

family deductible, each family member's (including a newborn's) covered expenses (medical and prescription drug expenses) count toward the family deductible. Once this family deductible is met, the Plan will pay benefits for all family members.

Do I have to meet a new deductible every year?

You and your family members will have to meet a new deductible each year.

What expenses apply toward the deductible?

Most of your medical expenses apply toward the deductible. Office visits (including ER and urgent care) and Prescription drug expenses do not apply to the deductible for the $350 Deductible Plan. Prescription drug expenses do not apply to the deductible for the $800 Deductible Plan.

Under the $1,500 Deductible Plan and the $2,500 Deductible Plan, prescription drug expenses (other than preventive drug expenses) also apply toward the deductible.

Refer to "Do preventive drug expenses apply toward the deductible?" on page 14 for further details.

Your payments for the following don't apply toward the Plan deductible:

- Amounts in excess of a reasonable and customary charge
- Prior Authorization penalties
- Services not covered by the Plan

Under the $350 Deductible Plan

- Prescription Drugs
- Office visit copays

Under the $800 Deductible Plan

- Prescription Drugs

Under the $1,500 Deductible Plan

- Amounts exceeding the network negotiated price for prescription drugs (other than preventive drugs)

Under the $2,500 Deductible Plan

- Amounts exceeding the network negotiated price for prescription drugs (other than preventive drugs)

Do preventive drug expenses apply toward the deductible?

Preventive drugs as defined by the Patient Protection Affordable Care Act for the $350 Deductible Plan, the $800 Deductible Plan, the $1,500 Deductible Plan and $2,500 Deductible Plan are covered with no cost sharing (i.e. deductible, coinsurance, copay). Certain examples include: aspirin products, fluoride products, iron supplements, folic acid products, immunizations, contraceptive methods, smoking cessation products, vitamin D supplements, bowel preps and primary prevention of breast cancer.

If you enrolled in the $1,500 Deductible Plan or the $2,500 Deductible Plan, there are certain preventive medications that are not subject to the deductible. Certain examples include: hypertension, diabetes, asthma, and cholesterol lowering drugs.

Call Express Scripts at +1 800 987 8360 for more information about preventive drugs or log on to the Drug Pricing Tool. Follow the provided steps to access the Drug Pricing Tool.

- Log on to express-scripts.com.
- Login or create an account.
- Manage prescriptions.
- Price a medication.
- Choose a pharmacy and enter drug name.

Out-of-Pocket Maximums

The maximum amount you have to pay toward the cost of the medical care you receive in the course of one year (excluding your per paycheck contributions to participate in the Plan). The out-of-pocket maximums vary under each of the medical plan options as follows:

Plan feature	$350 Deductible Plan	$800 Deductible Plan	$1,500 Deductible Plan	$2,500 Deductible Plan
Out-of-pocket maximum (including DEDUCTIBLE)	***In-network:*** Employee: $2,000 Family: $4,000 ***Out-of-network:*** Employee: $4,000 Family: $8,000	***In-network:*** Employee: $2,400 Family: $4,800 ***Out-of-network:*** Employee: $4,800 Family: $9,600	***In-network:*** Employee: $3,000 Family: $6,000 ***Out-of-network:*** Employee: $6,000 Family: $12,000	***In-network:*** Employee: $4,500 Family: $9,000 ***Out-of-network:*** Employee: $9,000 Family: $18,000

Prescription drug expenses apply toward the out-of-pocket maximum.

The out-of-pocket maximum doesn't apply to:

- Amounts exceeding Plan limits
- Amounts in excess of a reasonable and customary charge
- Prior Authorization penalties
- Services not covered by the Plan
- Amounts exceeding the network negotiated price for PRESCRIPTION DRUGS.

Your deductible applies toward your out-of-pocket maximum.

Do in-network claims apply toward the out-of-network out-of-pocket maximum?

No. Only out-of network claims apply toward the out-of-network out-of-pocket maximum.

Do out-of-network claims apply toward the in-network out-of-pocket maximum?

Yes. Out-of-network claims apply toward the in-network out-of-pocket maximum. Also, in-network claims apply toward the in-network out-of-pocket maximum.

How does the annual out-of-pocket maximum (limit) work for family members?

Under the $350 Deductible Plan

The Plan will begin reimbursing benefits for a covered family member (including a newborn) at 100% once he or she has met the individual out-of-pocket maximum (even if the entire family out-of-pocket maximum has not been met).

Under the $800 Deductible Plan

The Plan will begin reimbursing benefits for a covered family member (including a newborn) at 100% once he or she has met the individual out-of-pocket maximum (even if the entire family out-of-pocket maximum has not been met).

Under the $1,500 Deductible Plan

In meeting your family out-of-pocket maximum, each family member's (including a newborn's) covered expenses (medical and prescription drug expenses) count toward the family out-of-pocket maximum.

If you cover ELIGIBLE FAMILY MEMBERS, you must meet the family out-of-pocket maximum. Once this out-of-pocket maximum has been met, the Plan will pay benefits for all family members at 100% for IN-NETWORK PROVIDERS and 100% of reasonable and customary charges for OUT-OF-NETWORK PROVIDERS.

Under the $2,500 Deductible Plan

In meeting your family out-of-pocket maximum, each family member's (including a newborn's) covered expenses (medical and prescription drug expenses) count toward the family out-of-pocket maximum.

If you cover eligible family members, you must meet the family out-of-pocket maximum. Once this out-of-pocket maximum has been met, the Plan will pay benefits for all family members at 100% for in-network providers and 100% of reasonable and customary charges for out-of-network providers.

Networks

Is there a network of doctors and hospitals that I have to use?

Using the network is not mandatory, but generally, you will receive a higher reimbursement when using the network. If you use an in-network provider, you will be reimbursed 80% (70% under the $2,500 DEDUCTIBLE Plan). If you use an out-of-network provider, you will be reimbursed 60% (50%

under the $2,500 Deductible Plan) of reasonable and customary charges for covered expenses after the Plan's deductible has been met.

In the event that you receive care from an out-of-network doctor (such as an anesthesiologist) while being treated at an in-network facility, benefits will be paid at the in-network level.

The network includes general practitioners, as well as specialists and hospitals. These network providers are selected by and contracted with the Claims Administrator.

Important Information about Network Providers

Medica is your Claims Administrator if you live in the state of Minnesota, North Dakota or South Dakota or the county of Polk, Pierce, St. Croix, Burnett, Douglas, Bayfield, Ashland, Washburn, Sawyer, Barron, Dunn, Chippewa, or Eau Claire in Wisconsin. You must access a Medica Choice Network Provider in order to receive the Network level of benefits.

UnitedHealthcare is your Claims Administrator if you live in any other location within the United States. You must access a UnitedHealthcare Network Provider in order to receive the Network level of benefits.

Harvard Pilgrim Health Care network is the Claims Administrator if you live in Massachusetts, Maine and New Hampshire.

Where can I get a directory that lists all the doctors and hospitals in the network?

The doctors and hospitals in the network are listed in a provider directory. The Claims Administrator provides an online directory of providers available at www.myuhc.com. You may also call the Claims Administrator.

Is there a network of providers for mental health treatment?

There is a network of mental health providers. Providers in the network are listed in a provider directory. The Claims Administrator provides an online directory available at www.myuhc.com. You may also call the Claims Administrator.

Is there a network of pharmacies?

There is a pharmacy network associated with this Plan. You must use a pharmacy in the network to receive coverage under this Plan.

The Pharmacy Benefits Manager provides an online directory of network pharmacies available at www.expresss-scripts.com. You may also call the Pharmacy Benefits Manager.

Utilization Review

Which utilization review services are offered?

The Plan offers prior authorization and case management review.

You may obtain more information about these review services by calling the Claims Administrator.

What is Prior Authorization

Prior Authorization is a utilization review service performed by licensed healthcare professionals. The intent is to determine medical necessity and appropriateness of proposed treatment, level of care assessment, benefits and eligibility and appropriate treatment setting.

To obtain prior authorization for Covered Services from non-Network providers, call the toll-free number on the back of your ID card.

In many cases, your Non-Network Benefits will be reduced if the Claims Administrator has not provided prior authorization.

What services require prior authorization?

The following types of medical expenses require prior authorization or benefit determination, according to your Claims Administrator's medical policies:

- ambulance - non-emergent air;
- Clinical trials;
- Durable Medical Equipment for items that will cost more than $1,000 to purchase or rent, including diabetes equipment for the management and treatment of diabetes;
- Genetic testing – BRCA;
- home health care;
- HOSPICE care - INPATIENT;
- Hospital Inpatient Stay - all scheduled admissions;
- Lab, x-ray and diagnostics – OUTPATIENT – sleep studies;
- maternity care that exceeds the delivery timeframes;
- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management;
- Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders -inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Preservice, notification is also required for Benefits provided for Applied BehavioralAnalysis (ABA);
- obesity surgery;
- outpatient dialysis treatments;

- Reconstructive Procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery;
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;
- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management;
- Therapeutics - outpatient dialysis treatments, intensity modulated radiation therapy and MR-guided focused ultrasound as described under Therapeutic Treatments – Outpatient; and
- Transplants.
  - Maternity Admission if inpatient stay exceeds 48 hours after vaginal delivery and 96 hours after a cesarean delivery.
- Home Infusion Therapy (billed by home infusion specialist)
- Air Ambulance (air ambulance only suspends for medical review, there is no penalty applied)

If you have an emergency hospital admission, surgery or specified procedure, you, a family member, your physician or the hospital must notify your Claims Administrator within 48 hours of service.

If the procedure or treatment is performed for any condition other than an emergency condition, the call must be made at least 14 days before the date the procedure is to be performed or the treatment is to start. If it is not possible to make the call during the specified time, it must be made as soon as reasonably possible before the date the procedure or treatment is to be performed.

Do I need to have my maternity coverage prior authorized?

No. Prior Authorization within 48 hours is not required for the initial hospital admission.

You must notify the prior authorization service if the mother or her newborn stay in the hospital longer than 48 hours after a vaginal delivery or 96 hours after a Cesarean birth. This notification must occur within 24 hours of the determination to extend the stay.

When do I obtain prior authorization?

You, your family member or health care professional must obtain prior authorization as soon as you know you need a service requiring prior authorization, but not less than 14 days prior to the procedure or treatment.

Note: You are responsible for ensuring your service has been prior authorized.

How do I obtain prior authorization?

Initiate the prior authorization process by calling the Claims Administrator at the toll-free number on the back of your ID card.

What happens if I fail to obtain prior authorization?

If you fail to obtain prior authorization, your out-of-network benefits will be reduced by 50%. (Prior Authorization penalties do not apply towards your DEDUCTIBLE or out-of-pocket maximum.)

You are responsible for preauthorizing out-of-network services only. Your in-network provider will preauthorize all other services to the extent required by your Claims Administrator.

What approvals do I need if I am going into the hospital?

You must obtain prior authorization as soon as possible but at least 14 days before you are admitted for a non-emergency hospital admission or stay.

If you have an emergency hospital admission, surgery or specified procedure, you, a family member, your physician or the hospital must preauthorize within 48 hours of the service.

Case Management Review (Personal Health Support)

UnitedHealthcare provides a program called Personal Health Support (PHS) which is designed to encourage personalized, efficient care for you and your covered Dependents. Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Personal Health Support Nurse is notified when you or your provider calls the toll-free number on your ID card regarding an upcoming treatment or service.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse, to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and wellbeing.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice.

When you call to obtain prior authorization, a Personal Health Support Nurse can identify a major medical condition, that condition will be subject to case management review. Case management review aims at identifying major medical conditions early in the treatment plan and makes recommendations regarding the medical necessity of requested health care services.

Personal Health Support Nurses with experience in intensive medical treatment and rehabilitation provide case management services. The case manager works with the patient’s physician to identify available resources and develop the best treatment plan and may even recommend services and equipment

Situations that may benefit from case management include severe illnesses and injuries such as:

- Head trauma
- Organ transplants

- Burn cases
- Neo-natal high risk infants
- Multiple fractures
- HIV-related conditions
- Brain injuries
- Cancer
- Prolonged illnesses
- Degenerative neurological disorders (e.g. multiple sclerosis).

To best help the patient, the Personal Health Support Nurses should be involved from the earliest stages of a major condition. This service gives you access to a knowledgeable professional who will use his or her expertise to assist you and your physician in considering your treatment options.

If the Personal Health Support Nurses questions the necessity of the proposed hospital admission or procedure, a physician advisor may contact your physician to discuss your case and suggest other treatment options that are generally utilized for your condition. You, your physician, and the case manager will be informed of the outcome of the review, and the Claims Administrator will determine the level of benefit coverage you will receive. You and your physician will be notified of the utilization reviewer's recommendation by telephone and in writing. You will also be informed of the appeal process if the procedures your physician ultimately recommends are not covered under the Plan (as determined by the Claims Administrator).

What's Covered

Pre-existing Conditions

There are no exclusions, limitations or waiting periods for PRE-EXISTING CONDITIONs for you or any covered family members.

Are immunizations for business travel covered under the Plan?

The Plan covers immunizations for business travel.

Is acupuncture covered under the Plan?

The Plan covers acupuncture when it is:

- performed by a physician as a form of anesthesia in connection with surgery or dental procedure that is covered under the Plan.
- a form of Alternative Treatment as long as it is rendered by a certified/licensed individual.

Coverage is limited to 12 visits per year.

Are insulin pump syringes covered under the medical coverage?

Yes. Insulin pump syringes are covered under the medical coverage. Insulin pump syringes are not covered under the prescription drug coverage.

Can a prosthetic device be replaced?

The Plan covers the replacement of prosthetic devices when MEDICALLY NECESSARY.

Are wigs covered?

The Plan will pay benefits for wigs when medically necessary up to a maximum of $300 per year per covered member.

Preventive/Wellness Care

How is preventive/wellness care covered?

The Plan covers PREVENTIVE/WELLNESS CARE at:

Under the $350 Deductible Plan

- 100% for IN-NETWORK PROVIDERS with no DEDUCTIBLE and 60% of reasonable and customary charges for OUT-OF-NETWORK PROVIDERS after the Plan's deductible has been met. Plan limits apply. Contact the Claims Administrator for specific details.

Under the $800 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met. Plan limits apply. Contact the Claims Administrator for specific details.

Under the $1,500 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met. Plan limits apply. Contact the Claims Administrator for specific details.

Under the $2,500 Deductible Plan

- 100% for in-network providers with no deductible and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met. Plan limits apply. Contact the Claims Administrator for specific details.

Hearing exams for children under age 18 are covered when provided as part of a preventive/wellness visit.

What services are considered preventive/wellness care?

The Plan considers physician, testing and diagnostic fees for the following specific wellness expenses to be preventive/wellness care:

- Blood cell counts
- Blood tests for prostate screening
- Chest X rays

- Cholesterol tests
- EKG's
- Mammograms
- Pap smears
- Routine physical exams, including one pelvic exam each calendar year
- Sigmoidoscopy (covered if you are 50 and over.)
- Tuberculosis tests
- Urinalysis.

The following services are not considered preventive/wellness care:

- Services which are covered to any extent under any other group plan of your employer.
- Services which are for diagnosis or treatment of a suspected or identified injury or disease.
- Exams given while the person is confined in a hospital or other facility for medical care.
- Services which are not given by a physician or under his or her direct supervision.
- Medicines, drugs, appliances, equipment, or supplies.
- Psychiatric, psychological, personality or emotional testing or exams.
- Exams in any way related to employment.
- Premarital exams.
- Vision, hearing, or dental exams.

Does the Plan cover outpatient physician services?

The Plan covers charges for OUTPATIENT office visits at:

Under the $350 Deductible Plan

- $15 (PCP) or $30 (Specialist) per in-network office visit (no deductible) and 60% of reasonable and customary charges for out-of-network providers after the Plan deductible has been met.

Under the $800 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan deductible has been met.

Under the $2,500 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan deductible has been met.

Does the Plan cover gynecology visits?

The Plan covers one routine gynecological exam each calendar year at:

Under the $350 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

Under the $800 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

Under the $1,500 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

Under the $2,500 Deductible Plan

- 100% for in-network providers with no deductible and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

If the visit to the gynecologist is for treatment of a medical condition, it is not considered routine care and will be covered at:

Under the $350 Deductible Plan

- $15 (PCP) per office visit for in-network providers (no deductible) and 60% of reasonable and customary charges for out-of-network providers after the Plan deductible has been met

Under the $800 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan deductible has been met.

Under the $2,500 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers under after the Plan deductible has been met.

Does the Plan cover mammograms?

The Plan covers routine mammograms at:

Under the $350 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,500 Deductible Plan

- 100% for in-network providers with no deductible and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

There are no age or frequency limitations. It is recommended that members follow the American Cancer Society guidelines for age and frequency to determine when to receive preventive care services.

Does the Plan cover Pap smears?

The Plan covers one routine Pap smear each calendar year at:

Under the $350 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

Under the $800 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

Under the $1,500 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

Under the $2,500 Deductible Plan

- 100% for in-network providers with no deductible and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

If your doctor recommends a non-routine Pap smear as a follow up to a medical diagnosis, the Plan:

Under the $350 Deductible Plan

- requires a $15 copay for in-network providers (no deductible) and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $800 Deductible Plan

- covers your Pap smear at 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- covers your Pap smear at 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,500 Deductible Plan

- covers your Pap smear at 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Does the Plan cover prostate specific antigen (PSA) tests and routine Annual Digital Rectal exams?

The Plan covers routine prostate specific antigen (PSA) tests for covered males (with no age limitations) and routine Annual Digital Rectal Exam (DRE).

Under the $350 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

Under the $800 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

Under the $1,500 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

Under the $2,500 Deductible Plan

- 100% for in-network providers with no deductible and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

If your doctor recommends a non-routine DRE test as a follow-up to a medical diagnosis, the Plan covers your DRE test at:

Under the $350 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,500 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Maternity

Who is eligible for maternity coverage?

Maternity coverage is available to eligible covered female participants.

Do I need to have my maternity coverage preauthorized?

No. Prior authorization within 48 hours is not required for the initial hospital admission.

You must notify the prior authorization service if the mother or her newborn stay in the hospital longer than 48 hours after a vaginal delivery or 96 hours after a Cesarean birth. This notification must occur within 24 hours of the determination to extend the stay.

Does the Plan cover prenatal visits?

Note that routine prenatal care, as defined by the Department of Health and Human Services, is covered with no cost sharing (i.e. deductibles, coinsurance, copays) for all plans.

The Plan covers prenatal visits in-network at:

Under the $350 Deductible Plan

- $15 for the first office visit.

Under the $800 Deductible Plan

- 80% for IN-NETWORK PROVIDERS after the Plan DEDUCTIBLE has been met; first visit only.

Under the $1,500 Deductible Plan

- 80% for in-network providers after the Plan deductible has been met; first visit only.

Under the $2,500 Deductible Plan

- 70% for in-network providers after the Plan deductible has been met; first visit only.

After the first visit, subsequent visits are typically billed as part of doctor's delivery fee, which is also reimbursed at:

Under the $350 Deductible Plan

- 80% after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 80% after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 80% after the Plan's deductible has been met.

Under the $2,500 Deductible Plan

- 70% after the Plan's deductible has been met.

The Plan covers prenatal visits out-of-network at:

Under the $350 Deductible Plan

- 60% of reasonable and customary charges for OUT-OF-NETWORK PROVIDERS after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,500 Deductible Plan

- 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

What will the Plan pay for the doctor's charge for delivering the baby?

The Plan covers charges for delivery of the baby at:

Under the $350 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,500 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

What will the Plan pay for the doctor's charge for examining the baby?

The Plan covers the charges for your baby's first examination in the hospital at:

Under the $350 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,500 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

A child is covered at birth as long as the baby meets the child eligibility requirements and is enrolled within 60 days of the birth.

What will the Plan pay for hospital charges for the mother and the baby?

The Plan covers hospital charges for maternity admissions at:

Under the $350 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,500 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

The Plan covers newborn nursery care at:

Under the $350 Deductible Plan

- 80% for in-network providers with 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,500 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

A child is covered at birth as long as the baby meets the child eligibility requirements and is enrolled within 60 days of the birth.

The mother and the newborn child are covered for a minimum of 48 hours of care following a vaginal delivery and 96 hours following a Cesarean section. However, the mother's provider may — after consulting with the mother — discharge the mother earlier than 48 hours following a vaginal delivery (96 hours following a Cesarean section).

You must notify the precertification review service within 24 hours of a determination to extend the stay.

Does the Plan cover midwife services?

The Plan covers midwives who are in practice with a network group at:

Under the $350 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers in association with a supervising physician after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers in association with a supervising physician after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers in association with a supervising physician after the Plan's deductible has been met.

Under the $2,500 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers in association with a supervising physician after the Plan's deductible has been met.

What is the wellness program for Maternity?

The UHC Maternity Support Program provides tools and information to help your whole family have a successful pregnancy. Use this program throughout your pregnancy and after your baby is born to:

- Learn what's best for a healthy pregnancy
  - Receive materials on prenatal care, labor and delivery, newborn care and more
  - Get information for the father or domestic partner
  - Take a pregnancy risk survey and find out if you have any issues or risk factors that could affect your pregnancy
- If you have issues or risk factors that need special attention, the program's nurses provide personal case management to determine ways to lower your risks
- Get support to help quit smoking
- Reduce your risk for pre-term labor.

For more information about the UHC Maternity Support Program, call + 1 800 411 7984.

If my dependent child has a baby does the Plan cover the newborn child?

Unless the newborn meets the definition of an eligible child and is covered under the Plan, medical care for the newborn, whether in or out of the hospital, is not covered.

Family Planning

Does the Plan cover infertility treatment?

The Plan covers infertility treatments at:

Under the $350 Deductible Plan

- Subject to office visit copays (no DEDUCTIBLE) for IN-NETWORK PROVIDERS and 60% of reasonable and customary charges for OUT-OF-NETWORK PROVIDERS after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,500 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Benefits for infertility treatment are limited to a medical lifetime maximum of $15,000 per person.

Infertility treatments are covered as follows:

- Assisted reproduction procedures (including facility charges and related expenses) due to infertility
- Ovulation induction and monitoring
- Artificial Reproductive Technology (ART)
  - In vitro fertilization
  - Gamete intrafallopian transfer (GIFT)
  - Zygote intrafallopian transfer (ZIFT)
  - Cryopreserved embryo transfers
  - Intracytoplasmic sperm injection (ICSI) or ovum microsurgery.

Artificial insemination is considered an infertility treatment and is limited to the overall infertility medical lifetime maximum of $15,000 per person as noted in the infertility treatment sub-section.

You should obtain a PREDETERMINATION OF BENEFITS to determine your coverage and benefits for these services.

PRESCRIPTION DRUGS related to infertility are covered under the prescription drug benefit.

Are contraceptive devices covered under the Plan?

The Plan covers contraceptive devices at:

Under the $350 Deductible Plan

- 100% for in-network providers (no deductible) and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 100% for in-network providers (no deductible) and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 100% for in-network providers (no deductible) and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,500 Deductible Plan

- 100% for in-network providers (no deductible) and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Oral and injectable contraceptives are covered under the prescription drug plan.

Does the Plan cover vasectomy?

The Plan covers vasectomies at:

Under the $350 Deductible Plan

- Subject to office visit copays (no deductible) for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,500 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

You must obtain prior authorization before you are admitted to the hospital.

Vasectomy reversals are not covered under the Plan.

Does the Plan cover tubal ligation?

The Plan covers in-patient and OUTPATIENT tubal ligation at:

Under the $350 Deductible Plan

- 80% for in-network providers after deductible with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 80% for in-network providers after deductible with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers after deductible with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,500 Deductible Plan

- 70% for in-network providers after deductible with no deductible and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

You must obtain prior authorization before you are admitted to the hospital.

Tubal ligation reversals are not covered.

Inpatient Hospital and Physician Services

What will the Plan pay if I have to go to the hospital?

The Plan pays INPATIENT hospital charges at:

Under the $350 Deductible Plan

- 80% for IN-NETWORK PROVIDERS and 60% of reasonable and customary charges for OUT-OF-NETWORK PROVIDERS per admission after the Plan's DEDUCTIBLE has been met.

Under the $800 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers per admission after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers per admission after the Plan's deductible has been met.

Under the $2,500 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers per admission after the Plan's deductible has been met.

The Plan will cover the cost of a semi-private room. If you use a private room, the Plan will cover the amount up to the semi-private room rate.

You must obtain prior authorization as soon as possible but at least 14 days before you are admitted for a non-emergency hospital stay.

What approvals do I need if I am going into the hospital?

Prior authorization as soon as possible but at least 14 days before you are admitted for a non-emergency hospital admission or stay.

If you have an emergency hospital admission, surgery or specified procedure, you, a family member, your physician or the hospital must preauthorize within 48 hours of the service.

Does the Plan cover hospital visits by a physician?

While you are in the hospital, the Plan covers hospital visits by a physician at:

Under the $350 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,500 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Does the Plan cover ambulance charges?

The Plan covers transportation by ambulance to a medical facility at:

Under the $350 Deductible Plan

- 80% for in-network providers and 80% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 80% for in-network providers and 80% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 80% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,500 Deductible Plan

- 70% for in-network providers and 70% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Coverage includes charges for transportation to a hospital by air or water ambulance when:

- Ground ambulance transportation is not available.
- Your condition is unstable and requires medical supervision and rapid transport.
- In a medical emergency, transportation from one hospital to another hospital; when the first hospital does not have the required services or facilities to treat your condition and you need to be transported to another hospital and the above two conditions are met.

Does the Plan cover hospice care?

The Plan covers charges for HOSPICE at:

Under the $350 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,500 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

You must obtain prior authorization before you receive hospice care.

Mastectomy – Reconstructive Surgery

Does the Plan cover mastectomy-related services?

Yes, the Plan covers mastectomy-related services. Coverage will be provided in a manner determined by the attending physician and the patient. The covered services include:

- 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,
- Prostheses, and
- Treatment of physical complications of the mastectomy, including lymphedema.

What are the applicable deductibles and coinsurance for mastectomy-related benefits under the Plan?

The mastectomy-related benefits are subject to the same deductibles and COINSURANCE applicable to other medical and surgical benefits provided under this Plan. See the "Detailed List of Covered Services" on page 45 for the applicable mastectomy – reconstructive surgery coverage.

Obesity Surgery

The plan covers surgical treatment of obesity provided by or under the direction of a physician. Coverage is limited to once per person per lifetime.

Prior authorization under the condition of meeting the medical definition of morbid obesity is required. Contact the Claims Administrator for specific details.

Occupational Therapy

The plan covers the treatment to:

- Learn or re-learn daily living skills (e.g., bathing, dressing and eating) or compensatory techniques to improve the level of independence in the activities of daily living
- Provide task-oriented therapeutic activities designed to significantly improve, develop or restore physical functions lost or impaired as a result of a disease.

Coverage includes services, treatment, education testing or training related to developmental delays.

OUTPATIENT coverage is limited to 60 visits per year (combined in-network and out-of-network) per covered person (including physical therapy, occupational therapy, and speech therapy combined).

Prior authorization for occupational therapy is recommended. Contact the Claims Administrator for specific details.

Orthognathic Coverage

The Plan covers the diagnosis or treatment of the jawbones, excluding orthognathic surgery (procedure to correct underbite or overbite), and jaw alignment. Prior authorization is required. Contact the Claims Administrator for specific details.

See "What's Not Covered" on page 59 for orthognathic coverage exclusion.

Prescription Drugs

How does the Plan cover prescription drugs?

PRESCRIPTION DRUGS are covered as follows:

Prescription drugs	There is a pharmacy network for retail and Express Scripts by Mail for mail order prescription drugs.			
	$350 Deductible Plan	**$800 Deductible Plan**	**$1,500 Deductible Plan**	**$2,500 Deductible Plan**
Retail Prescriptions (30-day supply)				
▪ Generic	$10 (These amounts do not apply to the DEDUCTIBLE)	70% (These amounts do not apply to the deductible; minimum $10/maximum $20)	80% after deductible	70% after deductible
▪ Formulary Brand	$30 (These amounts do not apply to the deductible)	70% (These amounts do not apply to the deductible; minimum $25/maximum $50)	80% after deductible	70% after deductible
▪ Non-Formulary Brand	$60 (These amounts do not apply to the deductible)	55% (These amounts do not apply to the deductible; minimum $40/maximum $80)	80% after deductible	70% after deductible
Mail-order Prescriptions (90-day supply)				
▪ Generic	$25 (These amounts do not apply to the deductible)	70% (These amounts do not apply to the deductible; minimum $25/maximum $50)	80% after deductible	70% after deductible

Prescription drugs	There is a pharmacy network for retail and Express Scripts by Mail for mail order prescription drugs.			
	$350 Deductible Plan	**$800 Deductible Plan**	**$1,500 Deductible Plan**	**$2,500 Deductible Plan**
▪ Formulary Brand	$75 (These amounts do not apply to the deductible)	70% (These amounts do not apply to the deductible; minimum $62.50/maximum $125)	80% after deductible	70% after deductible
▪ Non-Formulary Brand	$150 (These amounts do not apply to the deductible)	55% (These amounts do not apply to the deductible; minimum $100/maximum $200)	80% after deductible	70% after deductible

Does the Plan cover formulary and non-formulary brand-name prescription drugs?

The Plan covers formulary and non-formulary prescription drugs purchased via the Plan's mail order service or a participating retail pharmacy.

To price medications and check formulary, visit www.express-scripts.com.

Unless your physician specifically prescribes a brand-name medication without substitution, prescriptions will be filled with the generic equivalent when allowed by state law.

Does the Plan cover generic drugs?

The Plan covers generic prescription drugs purchased via the Plan's mail order service or a participating retail pharmacy.

What happens if I buy a brand-name prescription drug when a generic drug is available?

Unless your physician specifically prescribes a brand name medicine without substitution, prescriptions will be filled with the generic equivalent when allowed by state law.

If you or your physician requests the brand-name prescription drug when a generic prescription drug is available and there is no medical reason for the brand-name prescription drug, you pay your share of the cost for the generic drug in addition to the difference between the brand-name prescription drug and generic prescription drug gross cost.

How does the Plan cover generic and brand-name contraceptive medications with no generic equivalent?

The Plan will cover generic and brand-name contraceptive medications **with no generic equivalent** at 100% in-network with no cost sharing as long as a valid prescription is submitted.

What is the Plan coverage for preventive drugs?

Preventive drugs as defined by the Patient Protection Affordable Care Act for the $350 Deductible Plan, the $800 Deductible Plan, the $1,500 Deductible Plan and $2,500 Deductible Plan are covered with no cost sharing (i.e. deductible, coinsurance, copay). Certain examples include: aspirin products, fluoride products, iron supplements, folic acid products, immunizations, contraceptive methods, smoking cessation products, vitamin D supplements, bowel preps and primary prevention of breast cancer.

If you enrolled in the $1,500 Deductible Plan or the $2,500 Deductible Plan, there are certain preventive medications that are not subject to the deductible. Certain examples include: hypertension, diabetes, asthma, and cholesterol lowering drugs.

Call Express Scripts at +1 800 987 8360 for more information about preventive drugs or log on to the Drug Pricing Tool. Follow the provided steps to access the Drug Pricing Tool.

- Log on to express-scripts.com.
- Login or create an account.
- Manage prescriptions.
- Price a medication.
- Choose a pharmacy and enter drug name.

The Pharmacy Benefits Manager provides an online directory of network pharmacies available at www.express-scripts.com. You may also call the Pharmacy Benefits Manager.

Is there a mail-order program?

The Plan's mail order service allows participants to order up to a 90-day supply of prescription medication by mail for certain medications. Using the mail order service for these medications will generally cost you less than using a retail pharmacy.

If I buy more than three fills of a prescription drug at a retail pharmacy, will I have to pay more?

For all maintenance prescription drugs, after purchasing the first three fills of a prescription drug (the initial fill plus two refills) at a participating retail pharmacy, if you choose to continue to fill the prescription at a retail pharmacy, you pay 50% of the negotiated price for up to a 30-day supply for all subsequent refills.

If I purchase a specialty medication at retail, will the prescription be covered?

If a specialty medication is filled at retail, the prescription will not be covered and amounts you pay for the not covered prescription will not accumulate to the out-of-pocket maximum.

Are any prescription drugs or drug supplies subject to limitations?

You may be subject to several different types of drug management programs. These include quantity management, prior authorization and qualification by history or step therapy.

Quantity Management

To ensure safe and effective drug therapy, certain covered medications may have quantity restrictions. These quantity restrictions are based on manufacturer and/or clinically approved guidelines and are **subject to periodic review and change**.

Select drug categories include:

- Antiemetic agents
- Antifungal agents
- Cancer therapy
- Cardiovascular agents
- Diabetic agents
- Fertility agents
- Hypnotic agents
- Migraine therapy
- Narcotic analgesics
- Non-narcotic analgesics
- Rheumatological agents
- Specialty medications.

The following are additional examples of prescription drugs or supplies that are covered with quantity limitations:

Drug or Supply	Quantity Limit
Erectile dysfunction drugs such as Viagra®, Cialis®, or Caverject®	6 units per prescription*
Inhaler spacers	2 spacers per year
Diabetic devices (blood glucose monitors)	1 monitor per year

* The maximum quantity of 6 units at retail or 18 units at mail order can be reached with one medication or any combination of many medications.

Prior Authorization

Certain medical treatments and prescription medicines need prior approval before the Plan will cover them. This requirement is to ensure the treatment or medication is appropriate and effective. If you do not receive approval, you will be responsible for paying the full cost.

Select drug categories include:

- Androgens and anabolic steroids
- Anorexiants
- Antinarcoleptics
- Cancer therapy
- Dermatologicals
- Specialty medications – require prior authorization under the Plan and are subject to quantity limitations as well
  - Examples of drug categories include: Botulinum Toxins (Botox), Growth Hormones, Hepatitis, Immune Globulins, Multiple Sclerosis, Myeloid Stimulants, Psoriasis, Pulmonary Arterial Hypertension (PAH), Rheumatoid Arthritis, RSV agents.

As new drugs become available or new indications are approved for already available drugs, the drugs that require prior authorization may be modified. To obtain prior authorization for coverage ask your doctor to call Express Scripts at +1 800 753 2851. After they receive the necessary information, you and your doctor will be notified confirming whether or not coverage has been approved.

Qualification by History (Step Therapy)

Some medications require the trial of another drug and/or require certain criteria such as age, sex, or condition (determined by previous claims history) to receive coverage. In these cases, a coverage review will be required if certain criteria cannot be determined from past history.

Select drug categories include:

- Cardiovascular agents
- COX-II Inhibitors
- Dermatologicals
- Migraine therapy
- Osteoporosis agents
- Specialty medications
  - Examples of drug categories include: Erythroid Stimulant, Fertility, Growth Hormone, Hepatitis, Multiple Sclerosis, Pulmonary Arterial Hypertension (PAH) agents.

As new drugs become available or new indications are approved for already available drugs, the drugs that may become subject to qualification by history rules may be modified.

Contact the Pharmacy Benefits Manager at +1 800 987 8360 for more information about any of these programs.

Are there any limitations on specialty prescription drugs?

The Accredo Recommended Days Supply Program maintains quantity limitations for certain specialty prescription drugs in accordance with FDA approval limits and to help reduce drug waste and prescription drug costs.

The first time you submit a claim for a specialty medication on this list, you will be limited to a 30-day supply for four months, even if your physician prescribed a 90-day supply. Your copayment will be prorated, so you will not be penalized for filling the prescription in 30-day supply increments instead of a 90-day supply.

An Accredo Representative will contact both you and your physician to explain why the prescription has been limited to a 30-day supply, discuss therapy and the disease state and discuss the importance of compliance.

In addition, specialty medications require prior authorization under the Plan and are subject to quantity limitations. These limits are subject to change and are discussed above.

Contact the Pharmacy Benefits Manager at +1 800 987 8360 for more information about any of these programs.

What prescription drugs and drug supplies are excluded from prescription drug coverage?

The following drugs and drug supplies are excluded from prescription drug coverage:

- Over-the-counter drugs (including topical contraceptives, nicotine products, vitamins and minerals, nutritional products including enteral products and infant formulas, homeopathic products and herbal remedies). Certain drugs will be covered with a prescription under Health Care Reform.
- Medical equipment and devices – insulin pumps, insulin pump syringes
- Home diagnostic kits
- All injectables (other than self-administered injectables and injectable drugs in connection with approved infertility treatment)
- Vaccines (except for zoster vaccine for shingles for adults age 60 and over) – [Note, these vaccines may be included under the medical coverage.]
- Allergy serums
- Plasma and blood products
- Drugs for cosmetic use
- Prescription products with an over the counter equivalent
- Investigational drugs, experimental use drugs, non-FDA approved drugs and compounds.

Note, you can receive the Pharmacy Benefits Manager's discounted price when you fill a prescription for a non-covered drug through the Pharmacy Benefits Manager's mail order program. You will pay 100% of the cost at the negotiated rate.

Is there a network of pharmacies?

There is a pharmacy network associated with this Plan. You must use a pharmacy in the network to receive coverage under this Plan.

The Pharmacy Benefits Manager provides an online directory of network pharmacies. You may also call the Pharmacy Benefits Manager.

How do I file a claim for benefits for prescription drugs?

All prescriptions filled at a participating retail pharmacy require you to provide an ID card for coverage under the Plan. You are responsible for the applicable copayment or coinsurance. Rarely will you need to file a claim with the Pharmacy Benefits Manager (one example may be a prescription filled at retail before you have received your ID card). To file a claim, contact the Pharmacy Benefits Manager.

Claim forms are available on the Pharmacy Benefits Manager's website. If you file a claim within 60 days of your effective date with the Plan, you will be reimbursed 100% of your out of pocket expense minus the appropriate coinsurance. After your 60 day grace period, you have 12 months from the date the expense was incurred to submit a claim. You are responsible for the difference between the discounted in-network price and the out-of-network price and the appropriate coinsurance.

Is there a separate ID card for the prescription drug program?

Yes, there is a separate ID card for the prescription drug program. If you are enrolled in medical coverage, you will automatically be sent a prescription drug ID card in addition to your medical plan ID card. You will be sent one additional prescription ID card if you enroll one or more family members in the program. Each ID card will list the names of all covered family members.

You may request additional ID cards directly from the Pharmacy Benefits Manager.

Mental Health/Substance Abuse

Does the Plan cover mental health/substance abuse services?

The Plan covers residential mental health/substance abuse treatment services, including residential treatment.

Does the Plan cover services in connection with autism?

The Plan covers treatments provided in connection with autism, except for education and experimental and investigational treatments.

Speech Therapy

The plan covers the treatment of:

- A speech impediment or speech dysfunction that results from injury, stroke or a congenital anomaly
- Delays in speech development.

OUTPATIENT coverage is limited to 60 visits per year per covered person (including physical therapy, occupational therapy, and speech therapy combined).

Prior authorization for speech therapy is recommended. Contact the Claims Administrator for specific details.

Gender Reassignment Surgery

Does the Plan cover transgender surgery?

Transgender surgery is covered for persons that meet all of the following conditions:

- You are at least 18 years old
- You have been diagnosed with “true” transsexualism
- You have completed a recognized program at a specialized gender identity treatment center.

Coverage is limited to one procedure per lifetime up to a maximum of $75,000 per person.

What transgender surgery benefits will the Plan pay?

The Plan will provide MEDICALLY NECESSARY benefits in connection with transgender surgery including transgender surgery travel expenses. The maximum individual limit is $75,000.

Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan.

Temporomandibular Joint (TMJ) Coverage

The Plan covers services for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by and under the direction of a physician. Coverage includes the diagnostic or surgical treatment required as a result of an accident, trauma, congenital defect, developmental defect or pathology.

- Diagnostic coverage includes examination, radiographs and applicable imaging studies, and consultation.
- Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections. Surgical treatment* includes arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations and TMJ implants.

  *Surgical treatment is provided if the following criteria are met:

  - There is clearly demonstrated radiographic evidence of significant joint abnormality.
  - Non-surgical treatment has failed to adequately resolve the symptoms.
  - Pain or dysfunction is moderate or severe.

See “What’s Not Covered” on page 59 for TMJ exclusions.

Detailed List of Covered Services

The Plan reimburses MEDICALLY NECESSARY covered services and supplies for the diagnosis and treatment for an illness or injury. The Claims Administrator determines whether the service or supply is covered and determines the amount to be reimbursed.

Most services and supplies are subject to a DEDUCTIBLE and COINSURANCE.

Your costs for out-of-network services apply toward the in-network deductible and out-of-pocket maximum. However, your costs for in-network services do not apply toward the out-of-network deductible and out-of-pocket maximum.

$350 Deductible Plan and $800 Deductible Plan

	$350 Deductible Plan		**$800 Deductible Plan**	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Alcohol and substance abuse	***Inpatient and Residential Treatment:*** 80% after deductible Prior Authorization is required ***Outpatient:*** $15 per visit (no deductible)	***Inpatient and Residential Treatment:*** 60% of R&C after deductible Prior Authorization is required ***Outpatient:*** 60% after deductible	***Inpatient and Residential Treatment:*** 80% after deductible Prior Authorization is required ***Outpatient:*** 80% after deductible	***Inpatient and Residential Treatment:*** 60% of R&C after deductible Prior Authorization is required ***Outpatient:*** 60% after deductible
Allergy testing and treatment	PCP: $15 per visit; Specialist: $30 per visit (allergy injections covered at 80% after deductible when no office visit charged)	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
Alternative medicine (Acupuncture)	Coverage limitations: ▪ Performed by a physician as a form of anesthesia in connection with surgery or dental procedure that is covered under the Plan. ▪ A form of Alternative Treatment as long as it is rendered by a certified/licensed individual. ▪ Limited to 12 visits per calendar year (combined in-network/out-of-network).		Coverage limitations: ▪ Performed by a physician as a form of anesthesia in connection with surgery or dental procedure that is covered under the Plan. ▪ A form of Alternative Treatment as long as it is rendered by a certified/licensed individual.	
Ambulance charges	80% after deductible	80% of R&C after deductible	80% after deductible	80% of R&C after deductible

	$350 Deductible Plan		$800 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Artificial insemination	$30 copay (no deductible) if service is performed in an office All other places of service: 80% after deductible Limited to overall infertility maximum of $15,000 per lifetime	60% of R&C after deductible Limited to overall infertility maximum of $15,000 per lifetime	80% after deductible Limited to overall infertility maximum of $15,000 per lifetime	60% of R&C after deductible Limited to overall infertility maximum $15,000 per lifetime
CAT / PET scans	80% after deductible CAT scans subject to prior authorization	60% of R&C after deductible CAT scans subject to prior authorization	80% after deductible CAT scans subject to prior authorization	60% of R&C after deductible CAT scans subject to prior authorization
Chiropractors	$30 per visit (no deductible) 30 visits per calendar year (combined in-network/out-of-network)	60% of R&C after deductible for up to 30 visits per calendar year (combined in-network/out-of-network)	80% after deductible for up to 30 visits per calendar year (combined in-network/out-of-network)	60% of R&C after deductible for up to 30 visits per calendar year (combined in-network/out-of-network)
Contraceptive devices (as defined as Preventive Prescriptions)	Covered at 100%, without deductible	60% of R&C after deductible	Covered at 100%, without deductible	60% of R&C after deductible
Cosmetic surgery	Not covered	Not covered	Not covered	Not covered
Dental treatment (covered only for accidental injury to sound teeth within 12 months)	80% after deductible; subject to office visit copay in office	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
Doctor delivery charge for newborns	80% after deductible	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
Durable medical equipment	80% after deductible Prior Authorization is required for purchase or rentals of certain DME	60% of R&C after deductible Prior Authorization is required for purchase or rentals of certain DME	80% after deductible Prior Authorization is required for purchase or rentals of certain DME	60% of R&C after deductible Prior Authorization is required for purchase or rentals of certain DME

	$350 Deductible Plan		$800 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Emergency room	$100, then 80% after deductible for life-threatening injury or illness (See "Life-threatening Illness or Injury in the "Glossary" on page 69).	$100, then 80% of R&C after deductible for life-threatening injury or illness (See "Life-threatening Illness or Injury in the "Glossary" on page 69).	80% after deductible for life-threatening injury or illness (See "Life-threatening Illness or Injury in the "Glossary" on page 69).	80% of R&C after deductible for life-threatening injury or illness (See "Life-threatening Illness or Injury in the "Glossary" on page 69).
Gynecology visits	Covered at 100% (not subject to deductible) for one routine exam each calendar year Subsequent visits – $15 copay	60% of R&C after deductible	Covered at 100% (not subject to deductible) for one routine exam each calendar year Subsequent visits – 80% after deductible	60% of R&C after deductible
Hearing care	80% after deductible; subject to office visit copays Routine hearing exams for children are covered at 100% when provided as part of a preventive/wellness visit. Covered hearing aids limited to $1,000 a year per ear (no coverage for hearing aids for degenerative hearing loss).	60% of R&C after deductible Covered hearing aids limited to $1,000 a year per ear (no coverage for hearing aids for degenerative hearing loss).	80% after deductible Routine hearing exams for children are covered at 100% when provided as part of a preventive/wellness visit. Covered hearing aids limited to $1,000 a year per ear (no coverage for hearing aids for degenerative hearing loss).	60% of R&C after deductible Covered hearing aids limited to $1,000 a year per ear (no coverage for hearing aids for degenerative hearing loss).
Home health care	80% after deductible for up to 120 home health care aid visits per calendar year for homebound patients (up to 4 hours each visit) Prior Authorization is required	60% of R&C after deductible for up to 120 home health care aid visits per calendar year for homebound patients (up to 4 hours each visit) Prior Authorization is required	80% after deductible for up to 120 home health care aid visits per calendar year for homebound patients (up to 4 hours each visit) Prior Authorization is required	60% of R&C after deductible for up to 120 home health care aid visits per calendar year for homebound patients (up to 4 hours each visit) Prior Authorization is required
Hospice care	80% after deductible Prior Authorization is required	60% of R&C after deductible Prior Authorization is required	80% after deductible Prior Authorization is required	60% of R&C after deductible Prior Authorization is required
Immunizations (routine)	Covered at 100% (not subject to deductible)	60% of R&C after deductible	Covered at 100% (not subject to deductible)	60% of R&C after deductible

	$350 Deductible Plan		$800 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Infertility Services	$30 copay (no deductible) if service is performed in an office 80% after deductible for all other places of service You should obtain a PREDETERMINATION OF BENEFITS Artificial Insemination and Advanced Reproductive Technology are limited to overall infertility maximum of $15,000 per lifetime maximum (combined in-network/out-of-network)	60% of R&C after deductible You should obtain a predetermination of benefits Artificial Insemination and Advanced Reproductive Technology are limited to overall infertility maximum of $15,000 per lifetime maximum (combined in-network/out-of-network)	80% after deductible You should obtain a predetermination of benefits Artificial Insemination and Advanced Reproductive Technology are limited to overall infertility maximum of $15,000 per lifetime maximum (combined in-network/out-of-network)	60% of R&C after deductible You should obtain a predetermination of benefits Artificial Insemination and Advanced Reproductive Technology are limited to overall infertility maximum of $15,000 per lifetime maximum (combined in-network/out-of-network)
Inpatient hospital services	80% after deductible Prior Authorization is required	60% of R&C after deductible Prior Authorization is required	80% after deductible Prior Authorization is required	60% of R&C after deductible Prior Authorization is required
Laboratory charges	80% after deductible	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
Magnetic resonance imaging – MRI	80% after deductible Prior Authorization is required	60% of R&C after deductible Prior Authorization is required	80% after deductible Prior Authorization is required	60% of R&C after deductible Prior Authorization is required
Mammograms (Routine)	Covered at 100% (not subject to deductible)	60% of R&C after deductible	Covered at 100% (not subject to deductible)	60% of R&C after deductible
Mastectomy – reconstructive surgery	80% after deductible	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
Maternity hospital stay	80% after deductible	60% of R&C after deductible	80% after deductible	60% of R&C after deductible

	$350 Deductible Plan		$800 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Mental health	***Inpatient and Residential Treatment*** 80% after deductible Subject to prior authorization ***Outpatient:*** $15 per visit	***Inpatient and Residential Treatment*** 60% after deductible Subject to prior authorization ***Outpatient:*** 60% after deductible	***Inpatient and Residential Treatment*** 80% after deductible Subject to prior authorization ***Outpatient:*** 80% after deductible	***Inpatient and Residential Treatment*** 60% after deductible Subject to prior authorization ***Outpatient:*** 60% after deductible
Obesity Surgery	80% after deductible Copays apply if there are office visits Once per lifetime	60% of R&C after deductible Once per lifetime	80% after deductible Once per lifetime	60% of R&C after deductible Once per lifetime
Occupational therapy	$30 per visit; up to 60 visits per calendar year combined with physical and speech therapy (combined in-network/out-of-network)	60% of R&C after deductible; up to 60 visits per calendar year combined with physical and speech therapy (combined in-network/out-of-network)	80% after deductible; up to 60 visits per calendar year combined with physical and speech therapy (combined in-network/out-of-network)	60% of R&C after deductible; up to 60 visits per calendar year combined with physical and speech therapy (combined in-network/out-of-network)
Organ transplant	100% after deductible in Centers of Excellence as determined by the Claims Administrator. 80% after deductible Non-Centers of Excellence Prior Authorization is required	60% of R&C after deductible Prior Authorization is required	100% after deductible in Centers of Excellence (as determined by the Claims Administrator) 80% after deductible Non-Centers of Excellence Prior Authorization is required	60% of R&C after deductible Prior Authorization is required
Outpatient physician services	Preventive: 100% PCP: $15 per visit Specialist: $30 per visit Outpatient facility 80% after deductible	60% of R&C after deductible	Preventive: 100% Non-preventive: 80% after deductible	60% of R&C after deductible
Physical exams for adults (routine)	Covered at 100% (not subject to deductible or copays) for one physical exam each calendar year	60% of R&C after deductible for one physical exam each calendar year	Covered at 100% (not subject to deductible) for one physical exam each calendar year	60% of R&C after deductible for one physical exam each calendar year

	$350 Deductible Plan		$800 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Physical exams for children (routine)	Covered at 100% (not subject to deductible or copays) Subject to Plan limits	60% of R&C after deductible Subject to Plan limits	Covered at 100% (not subject to deductible) Subject to Plan limits	60% of R&C after deductible Subject to Plan limits
Physical therapy	$30 per visit; up to 60 visits per calendar year combined with occupational and speech therapy (combined in-network/out-of-network)	60% of R&C after deductible; up to 60 visits per calendar year combined with occupational and speech therapy (combined in-network/out-of-network)	80% after deductible; up to 60 visits per calendar year combined with occupational and speech therapy (combined in-network/out-of-network)	60% of R&C after deductible; up to 60 visits per calendar year combined with occupational and speech therapy (combined in-network/out-of-network)
Pregnancy termination	Subject to office visit copay, with no deductible in office 80% after deductible in other places of service	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
Prenatal visits	$15 copay (not subject to deductible) for first visit Routine Prenatal Care covered at 100%	60% of R&C after deductible	80% after deductible Routine Prenatal Care covered at 100%	60% of R&C after deductible
Private Duty Nursing	80% after deductible Maximum of 60 visits per calendar year (Combined in-network/out-of-network)	60% of R&C after deductible Maximum of 60 visits per calendar year (Combined in-network/out-of-network)	80% after deductible Maximum of 60 visits per calendar year (Combined in-network/out-of-network)	60% of R&C after deductible Maximum of 60 visits per calendar year (Combined in-network/out-of-network)
Prostate specific antigen test–- PSA (routine)	Covered at 100% (not subject to deductible)	60% of R&C after deductible	Covered at 100% (not subject to deductible)	60% of R&C after deductible
Prescription drugs (see "Drugs" on page 60	There is a pharmacy network for retail and mail order PRESCRIPTION DRUGS.	There is a pharmacy network for retail and mail order prescription drugs.	There is a pharmacy network for retail and mail order prescription drugs.	There is a pharmacy network for retail and mail order prescription drugs.

	$350 Deductible Plan		$800 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Sex transformation change (and related costs)	80% after deductible Service in physician office subject to copayment Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan. Subject to Plan limits (one per lifetime up to $75,000) (combined in-network/out-of-network)	60% of R&C after deductible Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan. Subject to Plan limits (one per lifetime up to $75,000) (combined in-network/out-of-network)	80% after deductible Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan. Subject to Plan limits (one per lifetime up to $75,000) (combined in-network/out-of-network)	60% of R&C after deductible Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan. Subject to Plan limits (one per lifetime up to $75,000) (combined in-network/out-of-network)
Skilled nursing facility	80% after deductible for up to 120 days per calendar year (combined in-network/out-of-network) Prior Authorization is required	60% of R&C after deductible for up to 120 days per calendar year (combined in-network/out-of-network) Prior Authorization is required	80% after deductible for up to 120 days per calendar year (combined in-network/out-of-network) Prior Authorization is required	60% of R&C after deductible for up to 120 days per calendar year (combined in-network/out-of-network) Prior Authorization is required
Speech therapy	$30 per visit; up to 60 visits per calendar year combined with occupational and physical therapy (combined in-network/out-of-network)	60% of R&C after deductible; up to 60 visits per calendar year combined with occupational and physical therapy (combined in-network/out-of-network)	80% after deductible; up to 60 visits per calendar year combined with occupational and physical therapy (combined in-network/out-of-network)	60% of R&C after deductible; up to 60 visits per calendar year combined with occupational and physical therapy (combined in-network/out-of-network)
Surgery	80% after deductible Prior Authorization is required Predetermination of benefits is recommended for multiple surgical procedures	60% of R&C after deductible Prior Authorization is required Predetermination of benefits is recommended for multiple surgical procedures	80% after deductible Prior Authorization is required Predetermination of benefits is recommended for multiple surgical procedures	60% of R&C after deductible Prior Authorization is required Predetermination of benefits is recommended for multiple surgical procedures

	$350 Deductible Plan		$800 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Tubal ligation	$30 copay (no deductible) if service is performed in an office Otherwise, 80% after deductible	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
Urgent Care	$50 per visit, deductible does not apply	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
Vasectomy	80% after deductible; subject to office visit copay if performed in an office	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
Vision care (routine eye exam)	Not covered	Not covered	Not covered	Not covered
Vision Therapy/ Orthoptics	$30 copay for treatment for convergency insufficiency	60% of R&C after deductible for treatment for convergency insufficiency	80% after deductible for treatment for convergency insufficiency	60% of R&C after deductible for treatment for convergency insufficiency
X-rays	80% after deductible	60% of R&C after deductible	80% after deductible	60% of R&C after deductible

$1,500 Deductible Plan and $2,500 Deductible Plan

	$1,500 Deductible Plan		$2,500 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Alcohol and substance abuse	***Inpatient and Residential Treatment:*** 80% after deductible Prior Authorization is required ***Outpatient:*** 80% after deductible	***Inpatient and Residential Treatment:*** 60% of R&C after deductible Prior Authorization is required ***Outpatient:*** 60% after deductible	***Inpatient and Residential Treatment:*** 70% after deductible Prior Authorization is required ***Outpatient:*** 70% after deductible	***Inpatient and Residential Treatment:*** 50% of R&C after deductible Prior Authorization is required ***Outpatient:*** 50% after deductible
Allergy testing and treatment	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible

	$1,500 Deductible Plan		$2,500 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Alternative medicine	Coverage limitations: ▪ Performed by a physician as a form of anesthesia in connection with surgery or dental procedure that is covered under the Plan. ▪ A form of Alternative Treatment as long as it is rendered by a certified/licensed individual. ▪ Limited to 12 visits per calendar year (combined in-network/out-of-network).		Coverage limitations: ▪ Performed by a physician as a form of anesthesia in connection with surgery or dental procedure that is covered under the Plan. ▪ A form of Alternative Treatment as long as it is rendered by a certified/licensed individual. ▪ Limited to 12 visits per calendar year (combined in-network/out-of-network).	
Ambulance charges	80% after deductible	80% of R&C after deductible	70% after deductible	70% of R&C after deductible
Artificial insemination	80% after deductible Limited to overall infertility maximum of $15,000 per lifetime (combined in-network/out-of-network)	60% of R&C after deductible Limited to overall infertility maximum of $15,000 per lifetime (combined in-network/out-of-network)	70% after deductible Limited to overall infertility maximum of $15,000 per lifetime (combined in-network/out-of-network)	50% of R&C after deductible Limited overall infertility maximum of to $15,000 per lifetime (combined in-network/out-of-network)
CAT / PET scans	80% after deductible CAT scans subject to prior authorization	60% of R&C after deductible CAT scans subject to prior authorization	70% after deductible CAT scans subject to prior authorization	50% of R&C after deductible CAT scans subject to prior authorization
Chiropractors	80% after deductible for up to 30 visits per calendar year combined in-network/out-of-network	60% of R&C after deductible for up to 30 visits per calendar year combined in-network/out-of-network	70% after deductible for up to 30 visits per calendar year combined in-network/out-of-network	50% of R&C after deductible for up to 30 visits per calendar year combined in-network/out-of-network
Contraceptive devices (as defined as Preventive Prescriptions)	Covered at 100%, without deductible	60% of R&C after deductible	Covered at 100%, without deductible	50% of R&C after deductible
Cosmetic surgery	Not covered	Not covered	Not covered	Not covered
Dental treatment (covered only for accidental injury to sound teeth within 12 months)	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible

	$1,500 Deductible Plan		$2,500 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Doctor delivery charge for newborns	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible
Durable medical equipment	80% after deductible Prior Authorization is required for purchase or rentals of certain DME	60% of R&C after deductible Prior Authorization is required for purchase or rentals of certain DME	70% after deductible Prior Authorization is required for purchase or rentals of certain DME	50% of R&C after deductible Prior Authorization is required for purchase or rentals of certain DME
Emergency room	80% after deductible for life-threatening injury or illness [(See "Life-threatening Illness or Injury in the "Glossary" on page 69).	80% of R&C after deductible for life-threatening injury or illness (See "Life-threatening Illness or Injury in the "Glossary" on page 69).	70% after deductible for life-threatening injury or illness (See "Life-threatening Illness or Injury in the "Glossary" on page 69).	70% of R&C after deductible for life-threatening injury or illness (See "Life-threatening Illness or Injury in the "Glossary" on page 69).
Gynecology visits	Covered at 100% (not subject to deductible) for one routine exam each calendar year Subsequent visits – 80% after deductible	60% of R&C after deductible	Covered at 100% (not subject to deductible) for one routine exam each calendar year Subsequent visits – 70% after deductible	50% of R&C after deductible
Hearing care	80% (after deductible) Routine hearing exams for children covered at 100% when provided as part of a preventive/ wellness visit. Covered hearing aids limited to $1,000 a year per ear (no coverage for hearing aids for degenerative hearing loss).	60% of R&C after deductible Covered hearing aids limited to $1,000 a year per ear (no coverage for hearing aids for degenerative hearing loss).	70% after deductible Routine hearing exams for children covered at 100% when provided as part of a preventive/ wellness visit. Covered hearing aids limited to $1,000 a year per ear (no coverage for hearing aids for degenerative hearing loss).	50% of R&C after deductible Covered hearing aids limited to $1,000 a year per ear (no coverage for hearing aids for degenerative hearing loss).
Home health care	80% after deductible for up to 120 home health care aid visits per calendar year for homebound patients (up to 4 hours each visit) Prior Authorization is required	60% of R&C after deductible for up to 120 home health care aid visits per calendar year for homebound patients (up to 4 hours each visit) Prior Authorization is required	70% after deductible for up to 120 home health care aid visits per calendar year for homebound patients (up to 4 hours each visit) Prior Authorization is required	50% of R&C after deductible for up to 120 home health care aid visits per calendar year for homebound patients (up to 4 hours each visit) Prior Authorization is required

	$1,500 Deductible Plan		$2,500 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Hospice care	80% after deductible Prior Authorization is required	60% of R&C after deductible Prior Authorization is required	70% after deductible Prior Authorization is required	50% of R&C after deductible Prior Authorization is required
Immunizations (routine)	Covered at 100% (not subject to deductible)	60% of R&C after deductible	Covered at 100% (not subject to deductible)	50% of R&C after deductible
Infertility Services	80% after deductible You should obtain a PREDETERMINATION OF BENEFITS Artificial Insemination and Advanced Reproductive Technology are limited to overall infertility maximum of $15,000 per lifetime maximum (combined in-network/out-of-network)	60% of R&C after deductible You should obtain a predetermination of benefits Artificial Insemination and Advanced Reproductive Technology are limited to overall infertility maximum of $15,000 per lifetime maximum (combined in-network/out-of-network)	70% after deductible You should obtain a predetermination of benefits Artificial Insemination and Advanced Reproductive Technology are limited to overall infertility maximum of $15,000 per lifetime maximum (combined in-network/out-of-network)	50% of R&C after deductible You should obtain a predetermination of benefits Artificial Insemination and Advanced Reproductive Technology are limited to overall infertility maximum of $15,000 per lifetime maximum (combined in-network/out-of-network)
Inpatient hospital services	80% after deductible Prior Authorization is required	60% of R&C after deductible Prior Authorization is required	70% after deductible Prior Authorization is required	50% of R&C after deductible Prior Authorization is required
Laboratory charges	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible
Magnetic resonance imaging – MRI	80% after deductible Prior Authorization is required	60% of R&C after deductible Prior Authorization is required	70% after deductible Prior Authorization is required	50% of R&C after deductible Prior Authorization is required
Mammograms (Routine)	Covered at 100% (not subject to deductible)	60% of R&C after deductible	Covered at 100% (not subject to deductible)	50% of R&C after deductible
Mastectomy – reconstructive surgery	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible
Maternity hospital stay	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible

	$1,500 Deductible Plan		$2,500 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Mental health	***Inpatient and Residential Treatment*** 80% after deductible Subject to prior authorization ***Outpatient:*** 80% after deductible	***Inpatient and Residential Treatment*** 60% after deductible Subject to prior authorization ***Outpatient:*** 60% after deductible	***Inpatient and Residential Treatment*** 70% after deductible Subject to prior authorization ***Outpatient:*** 70% after deductible	***Inpatient and Residential Treatment*** 50% after deductible Subject to prior authorization ***Outpatient:*** 50% after deductible
Obesity Surgery	80% after deductible Once per lifetime	60% of R&C after deductible Once per lifetime	70% after deductible Once per lifetime	50% of R&C after deductible Once per lifetime
Occupational therapy	80% after deductible; up to 60 visits per calendar year combined with physical and speech therapy (combined in-network/out-of-network)	60% of R&C after deductible; up to 60 visits per calendar year combined with physical and speech therapy (combined in-network/out-of-network)	70% after deductible; up to 60 visits per calendar year combined with physical and speech therapy (combined in-network/out-of-network)	50% of R&C after deductible; up to 60 visits per calendar year combined with physical and speech therapy (combined in-network/out-of-network)
Organ transplant	100% after deductible in Centers of Excellence as determined by the Claims Administrator 80% after deductible in Non-Centers of Excellence Prior Authorization is required	60% of R&C after deductible Prior Authorization is required	100% after deductible in Centers of Excellence as determined by the Claims Administrator 70% after deductible in Non-Centers of Excellence Prior Authorization is required	50% of R&C after deductible Prior Authorization is required
Outpatient physician services	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible
Physical exams for adults (routine)	Covered at 100% (not subject to deductible) for one physical exam each calendar year	60% of R&C after deductible for one physical exam each calendar year	Covered at 100% (not subject to deductible) for one physical exam each calendar year	50% of R&C after deductible for one physical exam each calendar year
Physical exams for children (routine)	Covered at 100% (not subject to deductible) Subject to Plan limits	60% of R&C after deductible Subject to Plan limits	Covered at 100% (not subject to deductible) Subject to Plan limits	50% of R&C after deductible Subject to Plan limits

	$1,500 Deductible Plan		$2,500 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Physical therapy	80% after deductible; up to 60 visits per calendar year combined with occupational and speech therapy (combined in-network/out-of-network)	60% of R&C after deductible; up to 60 visits per calendar year combined with occupational and speech therapy (combined in-network/out-of-network)	70% after deductible; up to 60 visits per calendar year combined with occupational and speech therapy (combined in-network/out-of-network)	50% of R&C after deductible; up to 60 visits per calendar year combined with occupational and speech therapy (combined in-network/out-of-network)
Pregnancy termination	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible
Prenatal visits	80% after deductible Routine Prenatal Care covered at 100%	60% of R&C after deductible	70% after deductible Routine Prenatal Care covered at 100%	50% of R&C after deductible
Private Duty Nursing	80% after deductible Maximum of 60 visits per calendar year (Combined in-network/out-of-network)	60% of R&C after deductible Maximum of 60 visits per calendar year (Combined in-network/out-of-network)	80% after deductible Maximum of 60 visits per calendar year (Combined in-network/out-of-network)	60% of R&C after deductible Maximum of 60 visits per calendar year (Combined in-network/out-of-network)
Prostate specific antigen test – PSA (routine)	Covered at 100% (not subject to deductible)	60% of R&C after deductible	Covered at 100% (not subject to deductible)	50% of R&C after deductible
Prescription drugs	There is a pharmacy network for retail and mail order prescription drugs.	There is a pharmacy network for retail and mail order prescription drugs.	There is a pharmacy network for retail and mail order prescription drugs.	There is a pharmacy network for retail and mail order prescription drugs.
Sex transformation change (and related costs)	80% after deductible Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan. Subject to Plan limits (one per lifetime up to $75,000; combined in-network/out-of-network)	60% of R&C after deductible Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan. Subject to Plan limits (one per lifetime up to $75,000; combined in-network/out-of-network)	70% after deductible Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan. Subject to Plan limits (one per lifetime up to $75,000; (combined in-network/out-of-network)	50% of R&C after deductible Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan. Subject to Plan limits (one per lifetime up to $75,000; combined in-network/out-of-network)

	$1,500 Deductible Plan		$2,500 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Skilled nursing facility	80% after deductible for up to 120 days per calendar year (combined in-network/out-of-network) Prior Authorization is required	60% of R&C after deductible for up to 120 days per calendar year) (combined in-network/out-of-network) Prior Authorization is required	70% after deductible for up to 120 days per calendar year (combined in-network/out-of-network) Prior Authorization is required	50% of R&C after deductible for 120 days per calendar year (combined in-network/out-of-network) Prior Authorization is required
Speech therapy	80% after deductible; up to 60 visits per calendar year combined with occupational and physical therapy (combined in-network/out-of-network)	60% of R&C after deductible; up to 60 visits per calendar year combined with occupational and physical therapy (combined in-network/out-of-network)	70% after deductible; up to 60 visits per calendar year combined with occupational and physical therapy (combined in-network/out-of-network)	50% of R&C after deductible; up to 60 visits per calendar year combined with occupational and physical therapy (combined in-network/out-of-network)
Surgery	80% after deductible Prior Authorization is required Predetermination of benefits is recommended for multiple surgical procedures	60% of R&C after deductible Prior Authorization is required Predetermination of benefits is recommended for multiple surgical procedures	70% after deductible Prior Authorization is required Predetermination of benefits is recommended for multiple surgical procedures	50% of R&C after deductible Prior Authorization is required Predetermination of benefits is recommended for multiple surgical procedures
Tubal ligation	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible
Urgent Care	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible
Vasectomy	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible
Vision care (routine eye care)	Not covered	Not covered	Not covered	Not covered
Vision Therapy/ Orthoptics	80% after deductible for treatment for convergency insufficiency	60% of R&C after deductible for treatment for convergency insufficiency	70% after deductible for treatment for convergency insufficiency	50% of R&C after deductible for treatment for convergency insufficiency
X-rays	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible

What's Not Covered

The Plan 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.

The Claims Administrator may modify this list at their discretion, and you will be notified of any such change.

Alternative Treatments

- Acupressure
- Aroma therapy
- Hypnotism
- Massage therapy
- Rolfing
- Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

Comfort or Convenience

- Television
- Telephone
- Beauty/barber service
- Guest service
- 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
  - Devices and computers to assist communication and speech
- Home remodeling to accommodate a health need (such as, but not limited to, ramps and swimming pools).

Dental

- Dental care except when necessary because of accidental damage to an unrestored tooth. Such services must be performed by a Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry (DMD). Dental services for final treatment to repair the damage must be started within three months of the accident and completed in the calendar year or within the following calendar year.
- 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
- Dental implants
- Dental braces
- Dental X-rays, supplies and appliances and all associated expenses, including hospitalization 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
- Treatment of congenitally missing, malpositioned or super numerary teeth, even if part of a congenital anomaly.

Drugs

- Over-the-counter drugs and treatments

Experimental or Investigational Services or Unproven Services

Medical, surgical, diagnostic, psychiatric, substance abuse or health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the US 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 Pharmacopea 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.

Foot Care

- Except when needed for severe systemic disease:
  - Routine foot care (including the cutting or removal of corns and calluses)
  - Nail trimming, cutting, or debriding (surgical removal of tissue)
- 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
- Treatment of flat feet
- Treatment of subluxation (partial dislocation) of the foot
- Shoe orthotics

Medical Supplies and Appliances

- Devices used specifically as safety items or to affect performance in sports-related activities
- Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
  - Elastic stockings
  - Ace bandages
  - Gauze and dressings
  - Ostomy supplies
- Orthotic appliances that straighten or re-shape a body part (including some types of braces)

Tubings, nasal cannulas, connectors and masks are not covered except when used with durable medical equipment

Mental Health/Substance Abuse

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Services for mental health and substance abuse that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention

- Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Plan's prior authorization review service
- Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents
- Treatment provided in connection with or to comply with commitments, police detentions and other similar arrangements, unless authorized by the Plan's prior authorization review service
- Services incurred for behavioral health treatment in a residential facility, which are paid the same as behavioral health INPATIENT benefits
- Services or supplies for the diagnosis or treatment of mental illness, alcoholism or substance disorders that, in reasonable judgment of the Plan's prior authorization review service, 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 Plan's prior authorization review service's guidelines or best practices as modified from time to time.

The Plan's prior authorization review service 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

- Pastoral counselors
- Education and experimental investigational treatments provided in connection with autism; ABA
- Treatment provided in connection with tobacco dependency in excess of 8 visits per 12 months
- Routine use of psychological testing without specific authorization

Nutrition

- Megavitamin and nutrition based therapy
- Nutritional counseling for either individuals or groups, including weight loss programs, health clubs and spa programs, health clubs and spa programs except when necessary in treating chronic disease states in which dietary adjustment has a therapeutic role and is prescribed by a physician and furnished by a provider as preventive care (e.g., a registered dietician, licensed nutritionist or other qualified licensed health provision) recognized under the plan.

Nutritional and electrolyte supplements, including infant formula, donor breast milk, nutritional supplements, dietary 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.

Orthognathic Coverage Exclusion

The plan does not cover orthognathic services for the treatment of obstructive sleep apnea.

Physical Appearance

- Cosmetic procedures. Examples include:
  - Pharmacological regimens (e.g., systematic course of drugs), 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
  - Orthognathic surgery, for cosmetic reasons
- 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.
- Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
- Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

Wigs are generally excluded except in cases of hair loss due a severe medical condition or treatment.

Providers

- 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.
- Services performed by a provider with your same legal residence

- 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.

Reproduction

- Health services and associated expenses for infertility treatments (except those described under Infertility Treatment)
- Surrogate parenting
- The reversal of voluntary sterilization
- Fees or direct payment to a donor for sperm or ovum donations
- Monthly fees for maintenance and / or storage of frozen embryos.

Services Provided under Another Plan

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

TMJ

- Surface electromyography
- Doppler analysis
- Vibration analysis
- Computerized mandibular scan or jaw tracking
- Craniosacral therapy
- Orthodontics
- Occlusal adjustment

- Dental restorations
- Any charges for services that are dental in nature.

Transplants

- Health services for organ and tissue transplants, except those described under Organ Transplants
- Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person (Donor costs for removal are payable for a transplant through the organ recipient's benefits under the Plan)
- Health services for transplants involving mechanical or animal organs
- Any solid organ transplant (e.g. heart, lung, etc.; not blood, bone marrow, etc.) that is performed as a treatment for cancer
- Any multiple organ transplant not listed as a covered service.

Travel

- Health services provided in a foreign country, unless required as emergency health services
- Travel or transportation expenses to and from your home, even though prescribed by a physician.
  - Some travel expenses related to covered transplantation services may be reimbursed at the Claims Administrator's discretion, For example, travel for solid organ and bone marrow transplants in an approved facility more than 100 miles from your home is covered up to $50 per night for lodging, and up to $10,000 per episode of care for travel and lodging combined.

Vision and Hearing

- Purchase cost of eye glasses, contact lenses, or hearing aids
- Fitting charge for hearing aids, eye glasses or contact lenses
- 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.

Work-Related Accident and Illness

The Plan does not cover work-related accidents or illnesses. Work-related accidents and illnesses should be reported as soon as they occur to your Human Resources representative for consideration under the Worker's Compensation program.

All Other Exclusions

- Health services and supplies that do not meet the definition of a Covered Service

- 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
- Treatment for insomnia and other sleep disorders, dementia, neurological disorders and other disorders without a known physical basis
- 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
- 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
- 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
- Charges in excess of eligible expense or in excess of any specified limitation
- Custodial care
- Domiciliary care (e.g., group living arrangements)
- Respite care
- Rest cures
- Psychosurgery (brain surgery to treat psychiatric symptoms)
- Treatment of benign gynecomastia (abnormal breast enlargement in males)
- Medical and surgical treatment of excessive sweating (hyperhidrosis)
- Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea
- Appliances for snoring
- Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing
- Any charges higher than the reasonable and customary charge
- Any charge for services, supplies or equipment advertised by the provider as free

- Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency
- Any charges prohibited by federal anti-kickback or self-referral statues
- Any additional charges submitted after payment has been made and your account balance is zero
- Any charges by a resident in a teaching hospital where a faculty physician did not supervise services
- 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
- Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness, such as asthma or allergies
- Speech therapy to treat stuttering, stammering, or other articulation disorders.

Filing a Claim

How do I file a claim for benefits?

If you use an in-network provider, in almost all cases, you do not have to file a claim form. The provider will file a claim directly with the Claims Administrator. Once the claim is processed you will be billed for the appropriate COINSURANCE amount, DEDUCTIBLE (and applicable copays.

If you receive services from a provider who does not participate in the network, you need to file a claim form to receive benefits.

You can obtain a UnitedHealthcare Medical Claim Form on Colleague Connect (https://colleagueconnect.mmc.com). Click **Career & Rewards,** select **Career & Rewards Forms/Documents** under Resources and then click Medical/Dental/Prescription.

Read and follow the form's instructions. Be sure to file a separate claim form for each member of your family. Make copies of all itemized bills, and attach the originals to the claim form. You will also need to indicate whether you want the payment to go to the provider or to you.

Mail the completed claim form and all relevant documentation as the form instructs. You may include more than one bill with a claim, even if the bills are for different medical services.

You have 12 months following the date the expense was incurred to file a medical claim.

How long does it normally take to process a claim for benefits?

Most claims are normally processed within 10 business days after the claim is received by the Claims Administrator.

You can find out the status of your claims by visiting the Claims Administrator's website.

How do I file a prescription drug claim form?

All prescriptions filled at a participating retail pharmacy require you to provide an ID card for coverage under the Plan. You are responsible for the applicable COPAYMENT or coinsurance. Rarely will you need to file a claim with the Pharmacy Benefits Manager (one example may be a prescription filled at retail before you have received your ID card). Should you need to file a claim, contact the Pharmacy Benefits Manager.

Claim forms are available on the Pharmacy Benefits Manager's website. Should you need to file a claim you are responsible for the difference between the discounted and undiscounted price. You have 12 months from the date the expense was incurred to submit a claim.

How do I file a claim for hospital charges?

Hospitals will submit a claim from your hospital stay directly to the Claims Administrator. After receiving reimbursement from the Claims Administrator, the hospital will then bill you for any coinsurance or amount not eligible for reimbursement.

Be sure to review the hospital bill and to request an explanation of any charges that you question or do not understand. You should let the Claims Administrator know if you have a concern about the charges on your hospital bill.

You have up to 12 months following the date the expense was incurred to file a claim.

Can I be reimbursed for claims incurred outside the United States?

No, you cannot be reimbursed for services incurred outside the US unless they are considered emergency services. If you incur eligible emergency medical or prescription drug expenses while living or traveling outside of the US, your claim's processing will be expedited if the receipts are in English or if the person providing the services gives you a letter in English explaining the treatment. The Claims Administrator will convert the bill to US dollars using an exchange rate on the day the services were performed.

You have 12 months following the date the expense was incurred to file a claim.

What is an Explanation of Benefits (EOB)?

An Explanation of Benefits statement outlines how the amount of benefit, if any, was calculated. The statement also shows your year-to-date deductible and OUT-OF-POCKET EXPENSES. If you are due reimbursement, a check will be mailed to you with an explanation of benefits statement, or to the provider if you assigned payment.

An Explanation of Benefits statement lets you verify that the claim was processed correctly. Always read your statement carefully, checking to make sure that you were billed only for:

- Services you received, on the day(s) you received them, only from the provider of care
- The exact type of services you received (e.g., if you participated in a group therapy session, make sure that you are not billed for individual treatment)
- The amount you were told the treatment would cost

- The type of medication you received (e.g., if you receive generic medication, check that you are not billed for brand name medication).

If your statement lists services you did not receive, please notify the Claims Administrator.

If you authorize that reimbursement be made directly to your provider, both you and the provider will receive an Explanation of Benefits statement, and the provider receives payment.

What happens if I am overpaid for a claim?

If the Plan overpays benefits to you (or a covered family member), you are required to refund any benefit you receive from the Plan that:

- Was for an expense that you (or a covered family member) did not pay or were not legally required to pay;
- Exceeded the benefit payable under the Plan; or
- Is not covered by the Plan.

If a benefit payment is made to you (or a covered family member), which exceeds the benefit amount, this Plan has the right:

- To require the return of the overpayment on request; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of you or a covered family member.

For Flexible Spending Account Reimbursement

If you participate in the Health Care Flexible Spending Account and do not have a covered domestic partner, once your medical claim is processed, the Claims Administrator will automatically process your claim for reimbursement under your Health Care Flexible Spending Account.

If you cover a domestic partner, you receive services that are not covered under the Plan or you participate in the Limited Purpose Health Care Flexible Spending Account, your claims cannot be automatically reimbursed. Rather, you must submit a Flexible Spending Account (FSA) Claim Form.

Appealing a Claim

There are special rules, procedures and deadlines that apply to appeals of benefit determinations and denied claims and you have special legal rights under ERISA. Please refer to the *Administrative Information* section for a description of the appeal process.

Glossary

ACTIVELY-AT-WORK

You are “actively at work” if you are fulfilling your job responsibilities at a Company-approved location on the day coverage is supposed to begin (e.g., you are not out ill or on a leave of absence).

AFTER-TAX (POST-TAX) CONTRIBUTIONS

Contributions taken from your paycheck after taxes are withheld.

APPROVED SPOUSE AND DOMESTIC PARTNER

Adding a spouse or same gender or opposite gender domestic partner to certain benefits coverage is permitted upon employment or during the Annual Enrollment period for coverage effective the following January 1st if you satisfy the Plan's criteria, or immediately upon satisfying the Plan's criteria if you previously did not qualify. To obtain spousal or domestic partner coverage, you will need to complete an Affidavit of Eligible Family Membership declaring that:

Spouse / Domestic Partner

- You have already received a marriage license from a US state or local authority, or registered your domestic partnership with a US state or local authority.

Spouse Only

- Although not registered with a US state or local authority, your relationship constitutes a marriage under US state or local law (e.g. common law marriage or a marriage outside the US that is honored under US state or local law).

Domestic Partner Only

- Although not registered with a US state or local authority, your relationship constitutes an eligible domestic partnership. To establish that your relationship constitutes an eligible domestic partnership you and your domestic partner must:
  - Be at least 18 years old
  - Not be legally married, under federal law, to each other or anyone else or part of another domestic partnership during the previous 12 months
  - Currently be in an exclusive, committed relationship with each other that has existed for at least 12 months and is intended to be permanent
  - Currently reside together, and have resided together for at least the previous 12 months, and intend to do so permanently
  - Have agreed to share responsibility for each other's common welfare and basic financial obligations
  - Not be related by blood to a degree of closeness that would prohibit marriage under applicable state law.

Marsh & McLennan Companies reserves the right to require documentary proof of your domestic partnership or marriage at any time, for the purpose of determining benefits eligibility. If requested, you must provide documents verifying the registration of your domestic partnership with a state or local authority, your cohabitation and/or mutual commitment, or a marriage license that has been approved by a state or local government authority.

Once your Affidavit of Eligible Family Membership is completed and processed, you may cover the dependent child(ren) of your spouse or domestic partner.

Go to Colleague Connect **(https://colleagueconnect.mmc.com)**, click **Career & Rewards** and select **Mercer Marketplace benefits enrollment website** under Resources.

BEFORE-TAX (PRE-TAX) CONTRIBUTIONS

Contributions taken from your paycheck generally before Social Security (FICA and Medicare) and federal unemployment insurance (FUTA) taxes and other applicable federal, state, and other income taxes are withheld.

Claims Administrator/Pharmacy Benefits Manager

Vendor that administers the Plan and processes claims; the vendor's decisions are final and binding.

Coinsurance

The percentage of expenses you are responsible for paying after you meet your deductible.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

A federal law that lets you and your eligible family members covered by a group health plan extend group health coverage temporarily, at their own expense, at group rates plus an administrative fee, in certain circumstances when their coverage would otherwise end due to a "qualifying event", as defined under COBRA.

A "qualifying event" under COBRA includes loss of coverage as a result of your leaving the Company (other than for gross misconduct); a reduction in hours, your death, divorce or legal separation; your eligibility for Medicare, or a dependent child's loss of dependent status; or, if you are a retiree, loss of coverage due to the Company filing for bankruptcy.

Coordination of Benefits

You or a covered family member may be entitled to benefits under another group health plan (such as a plan sponsored by your spouse's employer) that pays part or all of your health treatment costs. If this is the case, benefits from this plan will be "coordinated" with the benefits from the other plan. In addition to having your benefits coordinated with other group health plans, benefits from this plan are coordinated with "no fault" automobile insurance and any payments recoverable under any workers' compensation law, occupational disease law or similar legislation.

Copayment

The flat dollar amount you pay for a certain type of health care expense.

Covered Service(s)

Medically necessary health services provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.

Covered health services must be provided:

- When the Plan is in effect,
- Prior to the effective date of any of the individual termination conditions set forth in this 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 group studies.

The Claims Administrator determines only the extent to which a service or goods or supplies is covered under the plan and not whether the service or goods or supplies should be rendered. The coverage determination is made using the descriptions of covered charges included in this section and the Claims Administrator's own internal guidelines. The decision to accept a service or obtain a goods or supplies is yours.

DEDUCTIBLE

The amount of out-of-pocket expenses you must pay for covered services before the plan pays any expenses.

DISABILITY

A physical or mental impairment that substantially limits one or more of an individual's major life activities.

ELIGIBLE FAMILY MEMBERS

Child/Dependent Child means:

- Your biological child
- A child for whom you or your spouse are the legally appointed guardian with full financial responsibility
- The child of an approved domestic partner
- Your stepchild
- Your legally adopted child or a child or child placed with you for adoption.

Note: Any child that meets one of these eligibility requirements and who is incapable of self support by reason of a total physical or mental disability as determined by the Claims Administrator, may be covered beyond the end of the calendar year in which the child attains age 26.

Dependent children are eligible for healthcare coverage until the end of the calendar year in which they attain age 26. This eligibility provision applies even if your child is married, has access to coverage through his or her employer, doesn't attend school full-time or live with you, and is not your tax dependent.

Note: While married children are eligible for healthcare coverage under your plan until the end of the calendar year in which they attain age 26, this provision does not apply to your child's spouse and/or child(ren), unless you or your spouse is the child's legally appointed guardian with full financial responsibility.

The Company has the right to require documentation to verify the relationship (such as a copy of the court order appointing legal guardianship). Company medical coverage does not cover foster children or other children living with you, including your grandchildren, unless you are their legal guardian with full financial responsibility—that is, you or your spouse claims them as a dependent on your annual tax return.

ELIGIBLE MMA EMPLOYEES

Eligible MMA employees are defined as employees classified on payroll as a US regular employee of MMA-Corporate, MMA-Alaska, MMA-Southwest, MMA-Northeast, or Security Insurance Services of Marsh & McLennan Agency.

ELIGIBLE MARSH & MCLENNAN COMPANIES EMPLOYEES (OTHER THAN MMA)

Marsh & McLennan Companies employees (other than MMA) are defined as employees classified on payroll as a US regular employee of Marsh & McLennan Companies or any subsidiary or affiliate of Marsh & McLennan Companies (other than MMA and any of its subsidiaries).

ELIGIBLE RETIREE

An employee is eligible for coverage under this plan if he/she is a US regular employee of Marsh & McLennan Companies or any subsidiary or affiliate of Marsh & McLennan Companies (other than MMA and any of its subsidiaries) who terminates employment with five or more years of vesting service at age 55 or later, or at age 65 and eligible for active employee medical coverage at retirement or is a current retiree (under or over age 65) enrolled in retiree medical coverage.

When you or a covered family member reach age 65 or is deemed to be eligible for Medicare, the person who is age 65 or is eligible for Medicare is no longer eligible for coverage under the Pre-65 Retiree Medical Plan.

Evidence of Insurability (EOI)

Evidence of Insurability (EOI) is proof of good health and is generally required if you do not enroll for coverage when you first become eligible. If the coverage level you are requesting requires such evidence or if you are increasing coverage. Establishing EOI may require a physical examination at the employee's expense. The EOI must be provided to and approved by the insurer/vendor before coverage can go into effect.

Experimental or Investigational Services

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

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

Exceptions:

If you are not a participant in a qualifying Clinical Trial and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB)

A summary of benefits processed by the Claims Administrator.

Global Benefits Department

Refers to the Global Benefits Department, located at 121 River Street, Hoboken, NJ 07030.

Health Insurance Portability and Accountability Act (HIPAA)

A Federal law, HIPAA imposes requirements on employer health plans including concerning the use and disclosure of individual health information.

Hospice

A hospice is an institution that provides counseling and medical services that could include room and board to terminally ill individuals. The hospice must have required state or governmental Certificate of Need approval and must provide 24 hour-a-day service under the direct supervision of a physician. The staff must include a registered nurse, a licensed social service worker and a full-time claims administrator. If state licensing exists, the hospice must be licensed.

IN-NETWORK PROVIDERS

Preferred health care providers who have agreed to charge reduced fees to members.

INPATIENT

Being treated and admitted at a covered facility for an overnight stay either by a physician or from the emergency room.

LIFE THREATENING ILLNESS OR INJURY– EMERGENCY ROOM COVERAGE

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part.

Some examples of emergencies include:

- Heart attack, suspected heart attack or stroke
- Suspected overdose of medication
- Poisoning
- Severe burns
- Severe shortness of breath
- High fever (103 degrees or higher), especially in infants
- Uncontrolled or severe bleeding
- Loss of consciousness
- Severe abdominal pain
- Persistent vomiting
- Severe allergic reactions.

The Plan covers emergency services necessary to screen and stabilize a member when:

- A primary care physician or specialist physician directs the member to the emergency room
- A plan representative (employee or contractor) directs the member to the emergency room
- The member acting as a prudent layperson and a reasonable person would reasonably have believed that an emergency condition existed.

MARSH & MCLENNAN COMPANIES MEDICAL PLANS AND MEDICARE PRESCRIPTION DRUG COVERAGE FOR DISABLED EMPLOYEES

Marsh & McLennan Companies newsletter that provides an overview of how Medicare Part D could affect your Marsh & McLennan Companies prescription drug coverage. It highlights issues you'll want to think about as you consider your prescription drug options.

The US Federal government's health insurance program, administered by the Social Security Administration, that pays certain hospital and medical expenses for those who qualify, primarily those who are over age 65 or under age 65 and are totally and permanently disabled. Medicare coverage is available regardless of income level. The program is government subsidized and operated.

MEDICALLY NECESSARY

Healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental Illness, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- in accordance with Generally Accepted Standards of Medical Practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your sickness, injury, mental illness, substance use disorder disease or its symptoms;
- not mainly for your convenience or that of your doctor or other health care provider; and
- not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on [**www.myuhc.com**, or **mymedica.com**, residents in MA, ME, NH use **www.myharvardpilgrim.org** or by calling the number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline].

MEDICARE

The US Federal government's health insurance program, administered by the Social Security Administration, that pays certain hospital and medical expenses for those who qualify, primarily those who are over age 65 or under age 65 and are totally and permanently disabled. Medicare coverage is available regardless of income level. The program is government subsidized and operated.

NOTICE OF CREDITABLE COVERAGE

The Medicare Modernization Act requires all group health plan sponsors that offer prescription drug coverage to provide notices to covered employees, retirees, and their dependents who are eligible for Medicare's new prescription drug benefit (Part D).

OUT-OF-NETWORK PROVIDERS

Non-preferred health care providers who do not charge reduced fees to members.

Out-of-pocket Expenses

Subject to the following, the maximum amount you have to pay (excluding your contributions to participate in the plan) toward the cost of your medical care in the course of one year. There are some services and charges that do not count towards the out-of-pocket maximum, such as amounts exceeding plan limits, amounts exceeding the network negotiated price for prescription drugs, amounts your physician or health care provider may charge above the reasonable and customary charge.

Outpatient

Treatment/care received at a clinic, emergency room or health facility without being admitted as an overnight patient.

A review service that helps ensure you receive proper treatment and services and that these services are provided in the appropriate setting.

Prior Authorization/Precertification/Utilization Review

You are responsible for preauthorizing out-of-network services only. Your in-network provider will preauthorize all other services to the extent required by your Claims Administrator.

Predetermination of Benefits

This feature helps you estimate how much the Plan may pay (subject to your deductible and Plan maximum at the time the estimate is provided) before you begin treatment. It is intended to avoid any misunderstanding about coverage or reimbursement, and it is not intended to interfere with your course of treatment.

Pre-existing Condition

A health problem you had and received treatment for before your current benefit elections took effect.

Prescription Drugs

- **Formulary/Brand Name (Preferred) Prescription Drugs.** A comprehensive list of preferred brand-name drug products that are covered under the plan. Preferred drugs are selected based on safety, effectiveness, and cost.
- **Generic Prescription Drugs.** Prescription drugs, whether identified by chemicals, proprietary or non-proprietary name, that are accepted by the FDA as therapeutically effective and interchangeable with drugs having an identical amount of the same active ingredient as its brand name equivalent.
- **Non-Formulary (Non-Preferred) Prescription Drugs.** Prescription drugs that do not appear on the formulary list are considered non-formulary or non-preferred; these drugs may either be excluded from coverage or may cost more.

Preventive/Wellness Care

Annual examinations or routine care covered under the plan; care that prevents or slows the course of an illness or disease or care that maintains good health.

Qualified Family Status Change (Status Change, Qualified Change in Family Status, Life or Family Change)

An event that changes your benefit eligibility. For example, getting married and having a child or your spouse or dependent lose other coverage. You can make certain changes to your before-tax benefit elections that are due to and consistent with the change in family status.

Qualified Medical Child Support Order (QMCSO)

A court order, judgment or decree that (1) provides for child support relating to health benefits under a plan with respect to the child of a group health plan participant or requires health benefit coverage of such child in such plan and is ordered under state domestic relations law or (2) is made pursuant to a state medical child support law enacted under Section 1908 of the Social Security Act. A QMCSO is usually issued requiring you to cover your child under your health care plan when a parent receiving post-divorce custody of the child is not an employee.

Qualifying Event

A “qualifying event” under COBRA includes loss of coverage as a result of your leaving the Company (other than for gross misconduct); a reduction in hours, your death, divorce or legal separation; your eligibility for Medicare, or a dependent child’s loss of dependent status; or, if you are a retiree, loss of coverage due to the Company filing for bankruptcy.

Reasonable & Customary (R&C) Charges/Fees

Charges/fees that do not exceed the prevailing charges for comparable services in your provider’s area. The Claims Administrator determines these limits based on the complexity of the service, the range of services provided and the prevailing charge level in the geographic area where the provider is located. The plan’s reasonable and customary guidelines include up to the 85th percentile of providers’ charges in the area.

The plan does not cover amounts charged by providers in excess of the reasonable and customary charge for any service or supply. The Claims Administrator regularly reviews the reasonable and customary charge schedule. To confirm whether your provider’s charges are within the reasonable and customary limit, obtain a Predetermination of Benefits.

Waiting Period/Elimination Period

The amount of time you must wait before being able to participate in a plan.