



Master Benefit Plan Document

Employees Retirement System of Texas HealthSelectSM of Texas Comprehensive Medical Care (Out-of-Area) Plan

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TABLE OF CONTENTS

SECTION 1 - WELCOME.....1

SECTION 2 - INTRODUCTION.....3

 Eligibility for the Texas Employees Group Benefits Program.....3

 Cost of Coverage.....4

 How to Select Coverage.....5

 When Coverage Begins.....5

 Changing Your Coverage.....6

SECTION 3 - HOW THE PLAN WORKS.....8

 Out-of-Area Benefits with Network and Non-Network Providers.....8

 Eligible Expenses (sometimes known as the Allowable Amount).....9

 Deductibles.....11

 Copayment.....12

 Coinsurance.....12

 Inpatient Copayment Maximum.....12

 Out-of-Pocket Coinsurance Maximum.....12

 Total Out-of-Pocket Maximum.....13

SECTION 4 - PRIOR AUTHORIZATION.....16

 Prior Authorization.....16

 Covered Health Services that Require Prior Authorization.....16

 Reduction in Benefits if Prior Authorization is Not Obtained.....18

 Special Note Regarding Medicare.....19

SECTION 5 - SCHEDULE OF BENEFITS AND COVERAGE.....20

SECTION 6 - DETAILS FOR COVERED HEALTH SERVICES.....32

 Acquired Brain Injury.....32

 Allergy Treatment.....32

 Ambulance Services.....33

 Bariatric Surgery.....33

 Chiropractic Treatment.....34

 Christian Science Practitioner Services.....35

 Clinical Trials.....35

 Congenital Heart Disease (CHD) Services.....36

 Dental Services.....37

 Diabetes Services.....39

Durable Medical Equipment (DME)	40
Emergency Room Services - Outpatient	42
Family Planning and Infertility Services	42
Habilitation and Rehabilitation Services - Outpatient Therapy	42
Hearing Aids	44
High-Tech Radiology - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient	44
Home Health Care	44
Hospice Care	45
Hospital - Inpatient Stay.....	46
Lab, X-Ray and Diagnostics - Outpatient	47
Mental Health Services.....	47
Neurobiological Disorders - Autism Spectrum Disorder Services	49
Nutritional Counseling.....	50
Ostomy Supplies.....	51
Pharmaceutical Products - Outpatient.....	51
Physician Fees for Surgical and Medical Services.....	51
Physician's Office Services - Sickness and Injury	51
Pregnancy - Maternity Services.....	52
Preventive Care Services	53
Private Duty Nursing - Outpatient.....	54
Prosthetic Devices	54
Reconstructive Procedures.....	55
Scopic Procedures - Outpatient Diagnostic and Therapeutic.....	56
Serious Mental Illness Services.....	57
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services.....	58
Substance Use Disorder Services.....	59
Surgery - Outpatient	60
Temporomandibular Joint (TMJ) Services and Orthognathic Surgery	61
Therapeutic Treatments - Outpatient.....	61
Transplant Services	62
Urgent Care Center Services.....	63
Vision Examinations	63
SECTION 7 - EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER	64
Alternative Treatments.....	64
Dental.....	65
Devices, Appliances and Prosthetics	65

Drugs	66
Educational Services	66
Experimental or Investigational or Unproven Services.....	67
Foot Care	67
Medical Supplies and Equipment	67
Mental Health/Substance Use Disorder Services.....	68
Nutrition.....	69
Personal Care, Comfort or Convenience.....	70
Physical Appearance	71
Procedures and Treatments	71
Providers.....	73
Reproduction/Infertility	73
Services Provided under Another Plan.....	74
Transplants	74
Travel	74
Types of Care	74
Vision and Hearing	75
All Other Exclusions.....	76
SECTION 8 - CLAIMS PROCEDURES	78
Out-of-Area Claims Processing for Network and Non-Network Services	78
If Your Provider Does Not File Your Claim	78
Claim Payment and Assignment.....	79
Health Statements	79
Explanation of Benefits (EOB).....	79
Claim Denials and Appeals.....	80
External Review Program	84
Authorized Representative	88
SECTION 9 - COORDINATION OF BENEFITS (COB).....	90
Determining Which Plan is Primary	90
When This Plan is Secondary.....	92
When a Participant Qualifies for Medicare	93
Overpayment and Underpayment of Benefits	94
SECTION 10 - SUBROGATION AND REIMBURSEMENT	95
Right of Recovery	95
Right to Subrogation.....	95
Right to Reimbursement	96

Third Parties.....	96
Subrogation and Reimbursement Provisions	96
SECTION 11 - WHEN COVERAGE ENDS.....	99
Extended Coverage	99
SECTION 12 - OTHER IMPORTANT INFORMATION.....	105
Qualified Medical Child Support Orders (QMCSOs)	105
Your Relationship with UnitedHealthcare and the Employees Retirement System of Texas.....	105
Relationships Between Network Providers, UnitedHealthcare and HealthSelect	105
Your Relationship with Providers.....	106
Interpretation of the Plan	106
Records.....	106
How to Access the Plan Document	107
SECTION 13 - GLOSSARY	108
SECTION 14 - IMPORTANT ADMINISTRATIVE INFORMATION.....	126
ATTACHMENT I - HEALTH CARE REFORM NOTICES.....	127
Patient Protection and Affordable Care Act ("ACA")	127
ATTACHMENT II - THE EMPLOYEES RETIREMENT SYSTEM OF TEXAS SUMMARY NOTICE OF PRIVACY PRACTICES.....	128
ADDENDUM - LIST OF COVERED PREVENTIVE CARE SERVICES	130
ADDENDUM - RESOURCES TO HELP YOU STAY HEALTHY	132
Personal Health Support.....	132
Resource Services for Specific Conditions.....	133
Consumer Solutions and Self-Service Tools	135
Disease and Condition Management Services.....	139
Wellness Programs.....	140
ADDENDUM - UNITEDHEALTH ALLIES	142
Introduction	142
What is UnitedHealth Allies?	142
Selecting a Discounted Product or Service	142
Visiting Your Selected Health Care Professional	142
Additional UnitedHealth Allies Information	142
ADDENDUM - PARENTSTEPS®	144
Introduction	144

What is ParentSteps? 144

Registering for ParentSteps..... 144

Selecting a Contracted Provider 144

Visiting Your Selected Health Care Professional 145

Obtaining a Discount 145

Speaking with a Nurse..... 145

Additional ParentSteps Information 145

SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Prior Authorization, Personal Health Support and Mental Health/Substance Use Disorder Administrator: (866) 336-9371 toll-free;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740809; Atlanta, GA 30374-0809; and
- Online assistance: www.myuhc.com/hs.

HealthSelect of TexasSM (HealthSelect) is a self-funded benefit plan offered through the Texas Employees Group Benefits Program (GBP or Program) by the Employees Retirement System of Texas (ERS).

HealthSelect is pleased to provide you with this Master Benefit Plan Document (MBPD), which describes the health Benefits available to you and your eligible covered family members. It includes information regarding:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

This MBPD is designed to meet your information needs. It supersedes any previous printed or electronic MBPD for this Plan.

IMPORTANT

The health care service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 13, *Glossary*.) The fact that a Physician or other Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorder, disease or its symptoms does not make the procedure or treatment a Covered Health Service under the Plan.

ERS intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice, or as directed by the state of Texas. This MBPD is not to be construed as a contract for any purposes or employment benefits.

UnitedHealthcare is a private health care claims administrator and the administering firm for HealthSelect. UnitedHealthcare's goal is to give you the tools you need to make wise health care decisions. UnitedHealthcare also helps HealthSelect to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. The Texas Employees Group Benefits Program, as administered by ERS, is ultimately responsible for paying Benefits described in this MBPD.

Please read this MBPD thoroughly to learn how the HealthSelect of Texas Comprehensive Medical Care (Out-of-Area Benefits) Plan works. If you have questions contact your Benefits Coordinator or call (866) 336-9371 toll-free.

How To Use This MBPD

- Read the entire MBPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this MBPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your MBPD and any future Amendments at **www.healthselectoftexas.com** or request printed copies by calling UnitedHealthcare at (866) 336-9371 toll-free.
- Capitalized words in the MBPD have special meanings and are defined in Section 13, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Participants as defined in Section 13, *Glossary*.
- The Employees Retirement System of Texas (ERS) is also referred to as the Plan Administrator.
- If there is a conflict between this MBPD, MBPD Amendments and any benefit summaries provided to you, this MBPD and its Amendments will control.

Please Note

Your Provider does not have a copy of your MBPD, and is not responsible for knowing or communicating your Benefits.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan;
- The factors that impact your cost for coverage;
- Instructions and timeframes for selecting coverage for yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

Eligibility for the Texas Employees Group Benefits Program

You are eligible to enroll in health coverage offered by the Texas Employees Group Benefits Program (GBP or Program) if you are a regular full-time or part-time State Agency Employee as defined in Section 13, *Glossary*, an Institution of Higher Education Employee as defined in Section 13, *Glossary*, or a Retiree as defined in Section 13, *Glossary*, with at least 10 years of service credit at the time of retirement, or required or permitted to enroll by Chapter 1551 of the Texas Insurance Code.

Eligibility for the Out-of-Area Benefits Plan

As an **Employee**, you are eligible for coverage in the Out-of-Area Benefits Plan if neither the county of your personal residence nor your place of employment is in the Plan Service Area:

- If you base your eligibility for coverage on the county of your personal residence and your residence is in the Plan Service Area, you must notify your Benefits Coordinator, or go to ERS Online at www.ers.state.tx.us to make the change, if you change your personal residence to a location outside the Plan Service Area. If the location of your residence changes from inside the Plan Service Area to outside the Plan Service Area, your coverage may change to the Out-of-Area Plan. If the location of your residence changes from outside the Plan Service Area to inside the Plan Service Area your coverage may change from the Out-of-Area Benefits Plan to the In-Area Benefits Plan.
- If you base your eligibility for the In-Area Plan on the county of your place of employment, then a change in location of residence will not cause a change in Plan.
- If you are over age 65 and Actively Working, you are eligible for coverage in the In-Area Plan, with Medicare as your Secondary plan.

As a **Retiree**, you may be eligible for coverage in the Out-of-Area Benefits Plan depending on which Plan you had before retirement, the county of your personal residence and your age.

If you are over age 65 and retired, you are eligible for the Out-of-Area Benefits Plan only.

If you are under age 65 and retired:

- If your personal residence is located outside the Plan Service Area, you are eligible for coverage in the Out-of-Area Benefits Plan.
- If, prior to retirement, you lived outside of the Plan Service Area but elected coverage in the In-Area Benefits Plan based on the county of your place of employment, you may elect to be covered in the In-Area Benefits Plan upon retirement. You may continue coverage in the In-

Area Benefits Plan until you either reach age 65 or change to the Out-of-Area Benefits Plan based on a change in residence outside of the Plan Service Area. Once you change to the Out-of-Area Benefits Plan, you may not change back to the In-Area Benefits Plan unless you, while under age 65, move your residence inside the Plan Service Area.

If you retire while under age 65, you are Medicare eligible, and your personal residence is located in the Plan Service Area, you are eligible under the In-Area Plan. However, Medicare is your Primary Plan and HealthSelect coverage is your Secondary Plan.

Your eligible **Dependents** may also participate in the Program and the Out-of-Area Benefits Plan. An eligible Dependent is considered to be:

- Subscriber's spouse – an individual to whom the Subscriber is legally married. This includes a ceremonially married spouse or an informally married spouse whose marriage is memorialized by a valid marriage license or Declaration of Informal Marriage filed with the appropriate governmental authority prior to the date of the spouse's enrollment in the Program;
- Subscriber's child who is under age 26, including a natural child, a stepchild, a foster child, a legally adopted child, a child placed for adoption or ward, as defined in Section 601, Texas Probate Code;
- a child who is related to the Subscriber by blood or marriage and was claimed as the Subscriber's Dependent on his/her federal income tax return for the year prior to enrolling the child and for each subsequent year in which the child is enrolled (unless the child is born in the year first enrolled or the Subscriber has a qualifying reason for not claiming the child);
- a child age 26 or over who lives with or has care provided by the Subscriber, and has been determined to be mentally or physically incapacitated; or
- a child who is at least 26 years of age and who is unmarried on the date of and following the expiration of the child's continuation coverage under COBRA. This child may continue coverage as a Former COBRA Unmarried Child.

An eligible Dependent who lives outside of the Plan Service Area may elect to participate in the Out-of-Area Benefits Plan even if the Subscriber, under whose coverage the Dependent is covered, participates in the In-Area Benefits Plan. If the Dependent returns to live in the Plan Service Area, he or she may elect to change participation to the In-Area Plan.

The Subscriber's Dependents may not enroll in a GBP health plan unless the Subscriber is also enrolled in a GBP health plan. The Subscriber and Dependents must be enrolled in the same health plan unless the Subscriber and/or Dependents have different Medicare eligibility status. If the Subscriber and his/her Dependent are both eligible to enroll in a GBP health plan as the Subscriber, he/she may each be enrolled as the Subscriber or be covered as a Dependent of the other person's plan, but not both. In addition, if you and your spouse are both Subscribers under a GBP health plan, only one parent may enroll your child as a Dependent on this Plan.

Cost of Coverage

The Subscriber and his/her Employer may share in the cost of the Plan. The Subscriber contribution amount may depend on GBP eligibility and length of enrollment and whether the Subscriber chooses to enroll any Dependents.

The Subscriber's contributions are deducted from his/her paychecks or annuity checks depending on the elections chosen. If the Subscriber is receiving retiree benefits, contributions will be deducted from his/her annuity post-tax. If the Subscriber is receiving full-time employee benefits,

then contributions would be deducted from his/her paycheck on a pre-tax basis. This means contributions are deducted before tax dollars come out of your check, before federal income and Social Security taxes are withheld, and (in most states) before state and local taxes are withheld. This gives the Subscriber's contributions a special tax advantage and lowers the Subscriber's actual out-of-pocket costs. The amount of contributions is subject to review, and the Employees Retirement System of Texas Board of Trustees reserves the right to change the contribution amount from time to time.

You can obtain current contribution rates by calling your Benefits Coordinator or logging on to www.ers.state.tx.us.

How to Select Coverage

On your eligibility date you are automatically enrolled in either the In-Area or Out-of-Area Plan, depending on your eligibility county or your age if you are a Retiree. If you do not want HealthSelect coverage, you must either select another coverage, if available, or waive coverage with your Benefits Coordinator or online, on or before your eligibility date.

If your Employer is an Institution of Higher Education, as defined in Section 13, *Glossary*, that participates in the GBP and your Employer pays the contribution for your health coverage for the first 60 days of employment, you are automatically enrolled in either the In-Area or Out-of-Area Plan, depending on your eligibility county, on the first day of Active Work. If you do not want HealthSelect coverage, you must either select another coverage, if available, or waive coverage with your Benefits Coordinator or online, on or before the 30th day of Active Work. The change in coverage is effective on the first day of the following month.

In order to enroll a Dependent, you must provide the Dependent information to your Benefits Coordinator on a Benefits Election Form and a Dependent Child Certification or online.

Important

If you wish to change your benefit elections following your marriage or the birth or adoption of a child, placement for adoption of a child or other family status change, you must contact your Benefits Coordinator, or make the change through ERS Online, within 31 days of the event. Otherwise, you will need to wait until the next Annual Enrollment to change your elections.

When Coverage Begins

Once your Benefits Coordinator receives your properly completed enrollment information, coverage for Subscribers will begin as follows:

- if you are new to the Program or you have a break in Active Service, on the first day of the month following the completion of a 60-day waiting period, unless the 60th day falls on the first day of a month; in which case coverage begins that day;
- if you have previous Program health coverage with no break in Active Service, on the first day of Active Work or retirement; or
- if you are employed by an Institution of Higher Education as defined in Section 13, *Glossary*, on the first day of Active Work if your Employer pays for coverage during the waiting period; otherwise on the first day of the month following the completion of a 60-day waiting period, unless the 60th day falls on the first day of a month; in which case coverage begins that day.

Coverage for the Subscriber's eligible Dependents will begin as follows:

- if the Subscriber is eligible for coverage without a waiting period and the Subscriber's Dependent information is received on or before the Subscriber's first day of eligibility, coverage will be effective on the first day of eligibility. If the Subscriber's Dependent information is received within 30 days after the Subscriber's eligibility date, the coverage will become effective on the first day of the month following receipt of the Dependent information; or
- if the Subscriber is subject to a waiting period and the Subscriber's Dependent information is received before the first day of the month after the 60-day waiting period, Dependent coverage will be effective on the first day of the month after the waiting period. If the Subscriber's Dependent information is not received before the first day of the month after the 60-day waiting period, then the Subscriber will need to wait until the next Annual Enrollment to add coverage for his or her eligible Dependents.

For eligible Dependents acquired after a Subscriber's eligibility date, or as addressed in the *Changing Your Coverage* subsection below, coverage will begin as follows:

- coverage for a spouse or Dependent stepchild that the Subscriber acquires via marriage becomes effective the first of the month following the date of the marriage, provided the Subscriber notifies his/her Benefits Coordinator or makes the change through ERS Online within 31 days of the date of the marriage;
- a newborn natural child is covered at birth for 31 days without enrollment and an adopted child is covered on the date of placement for adoption for 31 days without enrollment. However, the Subscriber must enroll the child within 31 days of the date of birth or placement for adoption to continue coverage beyond 31 days;
- an eligible newborn who is not the Subscriber's natural child and meets the definition of Dependent of the Subscriber is covered retroactively to the date of birth, provided that the Subscriber notifies his/her Benefits Coordinator or makes the change through ERS Online within 31 days of the birth; and
- coverage for an eligible Dependent who is the subject of a National Medical Support Notice is effective on the first day of the following month following the effective date of the National Medical Support Notice.

If You Are Hospitalized When Your Coverage Begins

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

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

Changing Your Coverage

You may make coverage changes during the Plan Year only if you experience a Qualifying Life Event (QLE), or during Annual Enrollment. The change in coverage must be consistent with the QLE (e.g., you cover your spouse following your marriage or your child following an adoption). The following are considered QLEs for purposes of the Plan:

- change in marital status;
- change in Dependent status;

- change in employment status;
- significant cost of Benefits or coverage change imposed by a third party;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- change of address that results in loss of coverage eligibility;
- change in Medicare, Medicaid, or Children's Health Insurance Program (CHIP) status; or
- an applicable National Medical Support Notice.

If you wish to change your elections, you must contact your Benefits Coordinator, or make the change through ERS Online, within 31 days of the Qualifying Life Event. Otherwise, you may not make a change until the next Annual Enrollment.

Notes:

- Any child who is placed with the Subscriber for adoption will be eligible for coverage on the date the child is placed with the Subscriber, even if the legal adoption is not yet final. If the Subscriber does not legally adopt the child, all Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.
- Any changes based on a Qualifying Life Event are effective on the first day of the month following the date of the QLE (except when a child is newborn, adopted or subject to a National Medical Support Order, as previously stated in this section).

Change in Coverage due to Qualifying Life Event - Example

Jane is married and has two children who are eligible Dependents. At Annual Enrollment, she elects not to participate in the GBP's health coverage, because her husband, Tom, has family coverage under his employer's medical plan. In October, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to Tom's change in employment status, Jane can elect family medical coverage under the GBP's health coverage outside of Annual Enrollment.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Out-of-Area Benefits with Network and Non-Network Providers;
- Eligible Expenses;
- Deductibles;
- Copayment;
- Coinsurance;
- Inpatient Copayment Maximum;
- Out-of-Pocket Coinsurance Maximum; and
- Total Out-of-Pocket Maximum.

Out-of-Area Benefits with Network and Non-Network Providers

As a Participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay.

Generally, when you receive Covered Health Services from a Network Provider, you pay less than you would if you receive the same care from a Non-Network Provider. Your level of Benefits will be the same if you visit a Network Provider or Non-Network Provider. However, because the total amount of Eligible Expenses may be less when you use a Network Provider, the portion you pay will be less. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network Provider.

Network Providers

UnitedHealthcare or its affiliates arrange for health care Providers to participate in a nationwide Network. At your request, UnitedHealthcare will send you a directory of Network Providers free of charge. Keep in mind, a Provider's Network status may change so the most up-to-date source of Network Providers is the HealthSelect dedicated website. To verify a Provider's status or request a Provider directory, you can call (866) 336-9371 toll-free or log onto www.healthselectoftexas.com.

Network Providers are independent practitioners and are not employees of HealthSelect, UnitedHealthcare or ERS.

Other than Providers designated through the UnitedHealth Premium Program, UnitedHealthcare's credentialing process confirms only public information about the Providers' licenses and other credentials, but does not assure the quality of the services provided. For information on Premium designated providers, including how to locate a UnitedHealth PremiumSM Physician, see *UnitedHealth Premium Program in Addendum - Resources to Help You Stay Healthy*, log onto www.healthselectoftexas.com or call (866) 336-9371 toll-free.

Non-Network Providers

When you receive health care services from a Non-Network Provider, you may also be required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Coinsurance Maximum. You may want to ask the Non-Network Provider about his/her billed charges before you receive care.

Looking for a Participating Network Provider?

In addition to other helpful information, www.healthselectoftexas.com, HealthSelect's dedicated website, contains a directory of health care professionals and Facilities in UnitedHealthcare's nationwide Network. While Network status may change from time to time, www.healthselectoftexas.com has the most current source of Network information. Use www.healthselectoftexas.com to search for Physicians available in your Plan.

Coverage While Traveling or Living Abroad

The Plan pays Benefits for a Participant while traveling or living outside the United States. Emergency services received outside the United States will be reimbursed at 70% of the Provider's billed charges and are subject to the Annual Deductible. Eligible Expenses for non-Emergency treatment received outside the United States are also reimbursed at the Out-of-Area Coinsurance level of 70%, subject to the Annual Deductible. However, non-Emergency services will be reimbursed as described for Non-Network Providers under the definition of Eligible Expenses in Section 14, *Glossary*. Any care received must be a Covered Health Service for Benefits to apply. You must pay the Provider at the time treatment is received and obtain appropriate documentation of services received and the cost of these services including itemized bills, receipts and any medical narrative. This information should be included when you submit your claim to UnitedHealthcare as described in Section 8, *Claims Procedures*. If you have any questions about Benefits while traveling or living abroad, or before you travel, please call UnitedHealthcare at (866) 336-9371 toll-free. To obtain an international claims form, go to www.myuhc.com/hs.

Don't Forget Your HealthSelect Medical ID Card

Remember to show your HealthSelect medical ID card every time you receive Covered Health Services from a Provider. If you do not show your ID card, a Provider has no way of knowing that you are enrolled in the Plan.

Eligible Expenses (sometimes known as the Allowable Amount)

Eligible Expenses are charges for Covered Health Services that are provided while the Plan is in effect, determined as described below.

For certain Covered Health Services, the Plan will not pay these expenses until you have met your Annual Deductible. For Covered Health Services from non-Network Providers, you are responsible for paying, directly to the non-Network Provider, any difference between the amount the Provider bills you and the amount UnitedHealthcare will pay for Eligible Expenses.

ERS has delegated to UnitedHealthcare the discretion to determine whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan, according to guidelines established by the Plan and/or UnitedHealthcare. ERS has the discretion to interpret all terms and conditions under the Plan, as described under *Interpretation of the Plan* in Section 12, *Other Important Information*.

Eligible Expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for Benefits. Eligible Expense determinations are subject to UnitedHealthcare's reimbursement policy guidelines, as described under the definition of Eligible Expenses in Section 13, *Glossary*.

Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network Provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.

- When Covered Health Services are received from a non-Network Provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.
- When Covered Health Services are received from a non-Network Provider, Eligible Expenses are determined, based on:
 - negotiated rates agreed to by the Non-Network Provider and either UnitedHealthcare or one of its vendors, affiliates or subcontractors, at the discretion of UnitedHealthcare.
 - if rates have not been negotiated, then one of the following amounts:
 - ◆ Eligible Expenses are determined based on 85% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the same geographic market; or
 - ◆ when a rate is not published by CMS for the service, UnitedHealthcare uses an available gap methodology to determine a rate for the service as follows:
 - for services other than Pharmaceutical Products, UnitedHealthcare uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, a comparable scale will be used. UnitedHealthcare and OptumInsight, Inc. are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at www.myuhc.com/hs for information regarding the vendor(s) that provides the applicable gap fill relative value scale information.
 - for Pharmaceutical Products, UnitedHealthcare uses gap methodologies that are similar to the pricing methodology used by CMS, and produces fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.
 - ◆ when a rate is not published by CMS for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the Provider's billed charge.
 - ◆ for Covered Health Services received on a non-Emergency basis at a Network Facility from a Non-Network Emergency care Physician, consulting physician, assistant surgeon, Durable Medical Equipment Provider, surgical assistant, radiologist, anesthesiologist or pathologist, the Eligible Expense is based on 110% of the published rates allowed by CMS for the same or similar service within the geographic market. When a rate is not published by CMS for the service, UnitedHealthcare uses a gap methodology established by OptumInsight and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, a comparable scale will be used. UnitedHealthcare and OptumInsight, Inc. are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at www.myuhc.com/hs for information regarding the vendor that provides the applicable gap fill relative value scale information. When a rate is not published by CMS for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the Provider's regular billed charge for the type of service claimed.

UnitedHealthcare updates the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data.

IMPORTANT NOTICE

Non-Network Providers may bill you for any difference between the Provider's billed charges and the Eligible Expense described above (which is sometimes referred to as "balance billing").

Deductibles

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each Calendar Year for Covered Health Services before you are eligible to begin receiving Benefits. The amounts you pay toward your Annual Deductible accumulate over the course of the Calendar Year.

Covered Health Services that are subject to the Annual Deductible and also subject to a visit or day limit will be included in reaching both the Annual Deductible and the maximum day or visit Benefit limit.

The Annual Deductible for each Participant is \$200, with a family maximum of \$600 per Calendar Year. However, if two or more Participants who are covered by the same Subscriber are injured in the same accident, the family maximum will not apply. Instead, only one Participant's Annual Deductible is required for the Calendar Year in which the accident occurred.

Eligible Expenses that apply to the Annual Deductible also apply to the Total Out-of-Pocket Maximum.

Bariatric Deductible

The Bariatric Deductible is the amount an Employee must pay for bariatric surgery before becoming eligible to begin receiving Network Benefits for such surgery. There is no coverage for bariatric surgery provided by a Non-Network Provider. Additionally, the bariatric surgery Benefit is not available to Retirees or Dependents.

The Bariatric Deductible is \$5,000.

Eligible Expenses that apply to the Bariatric Deductible do not apply to the Out-of-Pocket Coinsurance Maximum or Total Out-of-Pocket Maximum.

Note: For a complete description of guidelines and coverage for bariatric surgery, including the lifetime maximum benefit amount, refer to Section 5, *Schedule of Benefits and Coverage*, and Section 6, *Details for Covered Health Services*, under the heading *Bariatric Surgery*.

Additional Deductible

Before you are admitted to a Non-Network Hospital or other Facility for Inpatient care, whether for medical, mental health, Serious Mental Illness or substance-related and addictive disorder treatment, you must obtain Prior Authorization from UnitedHealthcare as described in Section 4, *Prior Authorization*.

If you do not obtain Prior Authorization, an Additional Deductible will apply before you are eligible to begin receiving Non-Network Benefits.

The Additional Deductible is \$200 and applies each time you fail to obtain Prior Authorization for admission to a Non-Network Hospital or other Facility for Inpatient care, whether for medical, mental health, Serious Mental Illness or substance-related and addictive disorder treatment as required.

Eligible Expenses that apply to the Additional Deductible also apply to the Out-of-Pocket Coinsurance Maximum; however they do not apply to the Annual Deductible.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the Provider. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Copays do not count toward the Out-of-Pocket Coinsurance Maximum nor toward the Annual Non-Network Deductible. However, Copays count toward the Total Out-of-Pocket Maximum.

Coinsurance

Coinsurance is a fixed percentage of Eligible Expenses that you are responsible for paying for certain Covered Health Services. The amount you pay for Coinsurance is determined after you meet the Annual Deductible and pay any applicable Copays.

The payments you make as Coinsurance apply to your Out-of-Pocket Coinsurance Maximum.

Examples

Coinsurance: Let's assume that you receive Plan Benefits for Durable Medical Equipment. Since the Plan pays 70% of Eligible Expenses, you are responsible for paying the other 30%. This 30% is your Coinsurance.

Copay: Let's assume that you receive Plan Benefits for a Hospital - Inpatient Stay. Your Copay is \$150 per day (up to a maximum of \$750 per admission). In this case you would also pay 30% Coinsurance, as the Plan pays 70% of Eligible Expenses after you pay the Copay.

Inpatient Copayment Maximum

The annual Inpatient Copayment Maximum is the most you pay each Calendar Year in Copays for Inpatient Stays in a Hospital or for Inpatient care for Mental Health Services, Serious Mental Illness Services or Substance Use Disorder Services. There is a combined Network and Non-Network Inpatient Copayment Maximum for this Plan. Once you reach the applicable Inpatient Copayment Maximum, you are not required to pay any more Inpatient Copays for the remainder of the Calendar Year.

When you pay any Inpatient Copayment for a Network or Non-Network Inpatient Stay under the In-Area Plan, it also applies toward the Inpatient Copayment Maximum under this Plan.

The Inpatient Copayment Maximum is separate from the Plan Out-of-Pocket Coinsurance Maximum. However, Copays for Inpatient Stays that apply to the Inpatient Copayment Maximum also apply to the Total Out-of-Pocket Maximum.

Out-of-Pocket Coinsurance Maximum

The annual Out-of-Pocket Coinsurance Maximum is the most you pay for Coinsurance each Calendar Year for Covered Health Services. Once you reach the applicable Out-of-Pocket Coinsurance Maximum, you will not be required to pay any more Coinsurance for the remainder of the Calendar Year.

If your eligible out-of-pocket Coinsurance expenses, except as noted below, in a Calendar Year exceed the annual maximum, the Plan pays 100% of Eligible Expenses, not including Copays, for Covered Health Services through the end of the Calendar Year.

Exceptions: Benefits for bariatric surgery are not paid at 100% even after the Out-of-Pocket Coinsurance Maximum is reached. The Plan will continue to pay these Benefits as shown in Table 3 in Section 5, *Schedule of Benefits and Coverage*.

Table 1 below identifies what does and does not apply toward your Out-of-Pocket Coinsurance Maximum.

Total Out-of-Pocket Maximum

The Total Out-of-Pocket Maximum is the Plan's overall limit on the amount you will pay out of pocket for your cost sharing for Covered Health Services each Calendar Year. The Total Out-of-Pocket Maximum includes Copays, Coinsurance and applicable Deductibles, as described below. Once you reach the Total Out-of-Pocket Maximum, you will not be required to pay any more out-of-pocket expenses for Benefits for the remainder of the Calendar Year, except as noted below.

Note: See Table 1 below and Table 2 in Section 5, *Schedule of Benefits and Coverage*, for details on what applies to the Out-of-Pocket Maximum.

If your eligible out-of-pocket expenses, except as noted below, in a Calendar Year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services for that level of Benefits through the end of the Calendar Year.

Exceptions: Benefits for bariatric surgery are not paid at 100% even after the Total Out-of-Pocket Maximum is reached. The Plan will continue to pay bariatric surgery as shown in Table 3 in Section 5, *Schedule of Benefits and Coverage*.

Table 1 below identifies what does and does not apply toward your Total Out-of-Pocket Maximum.

TABLE 1		
Plan Features	Applies to the Out-of-Pocket Coinsurance Maximum?	Applies to the Total Out-of-Pocket Maximum?
Copays, including those that apply to the Inpatient Copayment Maximum	No	Yes
Payments toward the Annual Deductible	No	Yes
Payments toward the Bariatric Deductible	No	No
Coinsurance payments for bariatric surgery	No	No
Coinsurance payments for all other Covered Health Services	Yes	Yes
Services or supplies that are for non-Covered Health Services excluded under the Plan	No	No
Expenses not covered because a maximum Benefit has been reached	No	No

TABLE 1		
Plan Features	Applies to the Out-of-Pocket Coinsurance Maximum?	Applies to the Total Out-of-Pocket Maximum?
Additional Deductible amounts you are required to pay if you do not obtain Prior Authorization from UnitedHealthcare for an Inpatient Stay at a Non-Network Hospital or other Facility*	No	Yes
Amounts you must pay out-of-pocket when no Benefits are paid by the Plan if you do not obtain Prior Authorization from UnitedHealthcare*	No	No
Charges that exceed Eligible Expenses as determined by UnitedHealthcare	No	No

*See *Reduction in Benefits if Prior Authorization is Not Obtained* in Section 4, *Prior Authorization*, for a list of services this applies to.

How the Plan Works - Example

The following example illustrates how the Annual Deductible, Out-of-Pocket Coinsurance Maximum, Total Out-of-Pocket Maximum and Coinsurance work in practice: Let's say Gary has individual coverage under the Plan. He has met his Annual Deductible and needs to see a Physician.

1. Gary goes to see a Physician, and presents his HealthSelect medical ID card.

|

2. He receives treatment from the Physician. The Plan's Eligible Expense for the visit is \$175.

|

3. The Physician's office requests no payment, informing Gary that it will bill UnitedHealthcare directly.*

|

4. After UnitedHealthcare processes the claim from the Provider, it is determined that Gary is responsible for paying Coinsurance directly to the Physician. Gary is responsible for \$52.50 (30% of \$175).

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5. Gary receives a bill from the Physician for the \$52.50, and pays the Physician directly. UnitedHealthcare pays \$122.50 to the Physician (70% of \$175).

UnitedHealthcare applies the \$52.50 toward Gary's Out-of-Pocket Coinsurance Maximum and Total Out-of-Pocket Maximum.

*Although Providers have the right to request payment in full at the time of service, in most cases they bill UnitedHealthcare directly.

SECTION 4 - PRIOR AUTHORIZATION

What this section includes:

- How to obtain Prior Authorization for certain Covered Health Services; and
- What services require Prior Authorization.

Prior Authorization

It is recommended that you confirm with UnitedHealthcare that all Covered Health Services listed below have been prior authorized as required.

The Plan requires Prior Authorization for certain Covered Health Services. In general, when Covered Health Services are provided by a participating UnitedHealthcare Network Provider, the Network Provider is responsible for obtaining Prior Authorization. There are some Covered Health Services, however, for which you are responsible for obtaining Prior Authorization. Covered Health Services for which Prior Authorization is required are identified below and in Section 6, *Details for Covered Health Services*, within each Covered Health Service category.

Before receiving these services from a Provider, you may want to contact UnitedHealthcare to determine whether the Hospital, Physician and other Providers are current Network Providers and if so, that they have obtained the required Prior Authorization. Network Facilities and Network Providers cannot bill you for services they fail to prior authorize as required. You may contact UnitedHealthcare by calling (866) 336-9371 toll-free.

To obtain Prior Authorization, call (866) 336-9371 toll-free. This call starts the utilization review process. The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Once you have obtained the authorization, please review the documentation carefully so that you understand what services have been authorized and what Providers are authorized to deliver the services that are subject to the authorization.

Covered Health Services that Require Prior Authorization

Network Covered Health Services

Network Providers are responsible for obtaining Prior Authorization from UnitedHealthcare before they provide most services to you.

However, there are some Network Benefits for which you are responsible for obtaining Prior Authorization from UnitedHealthcare.

The Network services that require **you** to request UnitedHealthcare authorization are:

- ambulance – non-emergent air;
- bariatric surgery;
- Congenital Heart Disease surgeries; and
- transplants.

For reductions in Benefits that apply if you do not obtain Prior Authorization from UnitedHealthcare or Bariatric Resource Services, as applicable, see below under *Reduction in Benefits if Prior Authorization is Not Obtained* as well as Section 6, *Details for Covered Health Services*.

Non-Network Covered Health Services

When you choose to receive certain Covered Health Services from Non-Network Providers, you are responsible for obtaining Prior Authorization from UnitedHealthcare before you receive these services. In many cases, your Non-Network Benefits will be reduced if UnitedHealthcare has not provided Prior Authorization, as described below under *Reduction in Benefits if Prior Authorization is Not Obtained*.

The Non-Network services that require **you** to request UnitedHealthcare authorization are:

- ambulance – non-emergent air;
- Congenital Heart Disease surgeries;
- Durable Medical Equipment that will cost more than \$1,000 to purchase or rent, including diabetes equipment for the management and treatment of diabetes;
- Genetic Testing – BRCA (breast cancer gene);
- high-tech radiology - CT, PET, MRI, MRA and nuclear medicine – outpatient including diagnostic catheterization and electrophysiology implants;
- home health care;
- Hospice care - Inpatient;
- Hospital Inpatient Stay - all scheduled admissions. **Note:** For Hospital Inpatient Stays:
 - the length of the Inpatient Stay must have Prior Authorization. The Provider may request additional days to be authorized, if needed; and
 - the transfer to another Hospital or to or from a specialty unit in a Hospital requires another Prior Authorization;
- lab, x-ray and diagnostics – outpatient - sleep studies;
- Mental Health Services - Inpatient Stay - all scheduled admissions (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility);
- Neurobiological Disorders - Autism Spectrum Disorder Services - Inpatient Stay - all scheduled admissions (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility);
- orthognathic surgery performed on an Inpatient basis;
- Pregnancy services for an Inpatient Stay that exceeds the number of hours allowed as described in Section 6, *Details for Covered Health Services*;
- Private Duty Nursing;
- prosthetic devices that will cost more than \$1,000 to purchase or rent;
- Reconstructive Procedures, including breast reduction surgery;
- Serious Mental Illness - Inpatient Stay - all scheduled admissions (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility);
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;
- Substance Use Disorder Services - Inpatient Stay - all scheduled admissions (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility);

- surgery – outpatient - cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators and sleep apnea surgeries as described under *Surgery - Outpatient* in Section 6, *Details for Covered Health Services*;
- therapeutic treatments – outpatient - all outpatient therapeutic treatments; and
- transplants.

For reductions in Benefits that apply if you do not obtain Prior Authorization from UnitedHealthcare, see below under *Reduction in Benefits if Prior Authorization is Not Obtained* as well as Section 6, *Details for Covered Health Services*.

Note: If you are admitted to a Non-Network Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility as a result of an Emergency, you or your representative must notify UnitedHealthcare within 48 hours after the admission.

Contacting UnitedHealthcare is easy.
Simply call (866) 336-9371 toll-free.

Reduction in Benefits if Prior Authorization is Not Obtained

If you do not obtain Prior Authorization for certain services listed above, your Benefits will be reduced:

- if you do not obtain Prior Authorization from UnitedHealthcare for bariatric surgery, you will be responsible for paying all charges and no Benefits will be paid;
- if you do not obtain Prior Authorization from UnitedHealthcare for these Non-Network services, Benefits will be subject to a \$200 Additional Deductible:
 - Congenital Heart Disease surgeries;
 - Hospital Inpatient Stay - all scheduled admissions;
 - orthognathic surgery performed on an Inpatient basis;
 - Pregnancy services for an Inpatient Stay that exceeds the number of hours allowed as described in Section 6, *Details for Covered Health Services*;
 - Reconstructive Procedures, including breast reduction surgery;
 - transplants; and
 - any other Inpatient Stay.
- if you do not obtain Prior Authorization from UnitedHealthcare for these Non-Network services, you will be responsible for paying all charges and no Benefits will be paid:
 - ambulance – non-emergent air;
 - Durable Medical Equipment that will cost more than \$1,000 to purchase or rent, including diabetes equipment for the management and treatment of diabetes;
 - Genetic Testing – BRCA;
 - high-tech radiology - CT, PET, MRI, MRA and nuclear medicine – outpatient including diagnostic catheterization and electrophysiology implants;
 - home health care;
 - Hospice care - Inpatient;
 - lab, x-ray and diagnostics - outpatient - sleep studies;
 - Private Duty Nursing;
 - prosthetic devices that will cost more than \$1,000 to purchase or rent;
 - Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;

- surgery – outpatient - cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators and sleep apnea surgeries; and
 - therapeutic treatments – outpatient - all outpatient therapeutic treatments.
- if you do not obtain Prior Authorization from UnitedHealthcare’s Mental Health/Substance Use Disorder Administrator for these Non-Network services, Benefits will be subject to a \$200 Additional Deductible:
- Mental Health Services - Inpatient Stay - all scheduled admissions (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility);
 - Neurobiological Disorders - Autism Spectrum Disorder Services - Inpatient Stay - all scheduled admissions (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility);
 - Serious Mental Illness - Inpatient Stay - all scheduled admissions (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) and Outpatient treatment for transcranial magnetic stimulation; and
 - Substance Use Disorder Services - Inpatient Stay - all scheduled admissions (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility).

Special Note Regarding Medicare

If you are enrolled in Medicare as your Primary Plan, Medicare pays benefits before the Plan and you are not required to obtain Prior Authorization from UnitedHealthcare before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 9, *Coordination of Benefits (COB)*.

SECTION 5 - SCHEDULE OF BENEFITS AND COVERAGE

Note: If you have Medicare coverage, see Section 9, *Coordination of Benefits*, for details on when and how HealthSelect will coordinate with Medicare.

Table 2 below contains the Plan's Copays, Annual Deductible, other deductibles, and maximums applicable for Covered Health Services.

TABLE 2	
Plan Features	Out-of-Area Coverage
Copays¹ (Copay is per visit unless otherwise stated)	
■ High-Tech Radiology - CT, PET, MRI, MRA and Nuclear Medicine – Outpatient	\$100
■ Hospital - Inpatient Stay (Copay is per day, up to a maximum of \$750 per admission and a maximum of \$2,250 per Calendar Year*)	\$150
■ Mental Health Services - Inpatient Stay (Copay is per day, up to a maximum of \$750 per admission and a maximum of \$2,250 per Calendar Year*)	\$150
*If you are discharged and then readmitted to the Hospital within 24 hours, the Copays you paid for the initial admission are combined with the Copay(s) for the readmission to reach the per-admission maximum.	
■ Surgery - Outpatient	\$100
Annual Deductible^{1,2}	
■ Participant, per Calendar Year	\$200
■ Family, per Calendar Year (not to exceed the applicable Individual amount per Participant)	\$600
Additional Deductible (applies each time you do not obtain Prior Authorization for a Non-Network Inpatient Stay)	\$200
Bariatric Deductible³	\$5,000

¹Copays do not apply toward the Annual Deductible or Out-of-Pocket Coinsurance Maximum. However, Copays apply toward the Total Out-of-Pocket Maximum.

²The Annual Deductible applies toward the Total Out-of-Pocket Maximum for all Covered Health Services. If two or more Participants who are covered by the same Subscriber are injured in the same accident, the family maximum will not apply. Instead, only one Participant's Annual Deductible is required for the Calendar Year in which the accident occurred.

³The Bariatric Deductible does not apply to the Out-of-Pocket Coinsurance Maximum or to the Total Out-of-Pocket Maximum.

TABLE 2	
Plan Features	Out-of-Area Coverage
Out-of-Pocket Coinsurance Maximum⁴ per Calendar Year, per Participant	\$3,000
Inpatient Copayment Maximum⁵ per Calendar Year, per Participant	\$2,250
Total Out-of-Pocket Maximum⁶	
■ Participant, per Calendar Year	\$6,350 <i>Effective January 1, 2016</i> \$6,450
■ Family, per Calendar Year (Effective January 1, 2016, not to exceed the applicable Individual amount per Participant)	\$12,700
Lifetime Maximum Benefit	Unlimited

⁴The Inpatient Copayment Maximum is separate from the Out-of-Pocket Coinsurance Maximum.

⁵Copays for Inpatient Stays that apply to the Inpatient Copayment Maximum also apply to the Total Out-of-Pocket Maximum.

⁶The Total Out-of-Pocket Maximum includes the Annual Deductible of \$200, the Out-of-Pocket Coinsurance Maximum of \$3,000, the Inpatient Copayment Maximum of \$2,250, any Additional Deductible paid (\$200 each) and any other Copayments. Until December 31, 2015, if you have family coverage, the Total Out-of-Pocket Maximum amount of \$12,700 could be satisfied by one or more persons covered by the Plan through this combination of Deductibles, Coinsurance and Copayments.

This Table 3 contains the percentages of Eligible Expenses that the Plan pays for the Covered Health Services listed. The percentage of Eligible Expenses not paid by the Plan is the Coinsurance for which you are responsible. For detailed descriptions of Covered Health Services and Benefits, refer to Section 6, *Details for Covered Health Services*.

TABLE 3	
Covered Health Services¹	Percentage of Eligible Expenses Payable by the Plan after Annual Deductible is Met:
Acquired Brain Injury	
■ Physician's Office Services	70%
■ Hospital - Inpatient Stay (Copay is \$150 per day, up to a maximum of \$750 per admission and a maximum of \$2,250 per Calendar Year)	70% after you pay the Copay
■ Physician Fees for Surgical and Medical Services	70%
■ Rehabilitation Services - Outpatient Therapy	70%
Allergy Treatment	70%
Ambulance Services (Emergency and Non-Emergency)	70% of billed charges
Bariatric Surgery (for Employees only) One surgery and maximum Benefits of \$13,000 per lifetime.	You must pay a \$5,000 Bariatric Deductible* specific to bariatric surgery before the Plan pays Benefits
■ Physician's Office Services	80%*
■ Physician Fees for Surgical and Medical Services	80%*
■ Hospital - Inpatient Stay (Copay is \$150 per day, up to a maximum of \$750 per admission and a maximum of \$2,250 per Calendar Year)	80%* after you pay the Copay
■ Lab and X-Ray	80%*
*Participant's Bariatric Deductible and Coinsurance do not apply to the Out-of-Pocket Coinsurance Maximum or Total Out-of-Pocket Maximum.	
Chiropractic Treatment Maximum Benefits of \$75 per visit and maximum of 30 visits per Calendar Year.	70%
Christian Science Practitioner Services	70%

TABLE 3	
Covered Health Services¹	Percentage of Eligible Expenses Payable by the Plan after Annual Deductible is Met:
Clinical Trials	
■ Physician's Office Services	70%
■ Physician Fees for Surgical and Medical Services	70%
■ Hospital - Inpatient Stay (Copay is \$150 per day, up to a maximum of \$750 per admission and a maximum of \$2,250 per Calendar Year)	70% after you pay the Copay
Congenital Heart Disease (CHD) Services	
■ Hospital - Inpatient Stay (Copay is \$150 per day, up to a maximum of \$750 per admission and a maximum of \$2,250 per Calendar Year)	70% after you pay the Copay
■ Physician's Office Services	70%
■ Physician Fees for Surgical and Medical Services	70%
■ Scopic Procedures - Outpatient Diagnostic and Therapeutic	70%
■ Surgery - Outpatient (Copay is \$100 per surgery)	70% after you pay the Copay
Dental Services	
■ Accident Related	70%
■ Medical Condition-Related	70%
■ Dental Anesthesia	
- Hospital - Inpatient Stay (Copay is \$150 per day, up to a maximum of \$750 per admission and a maximum of \$2,250 per Calendar Year)	70% after you pay the Copay
- Surgery - Outpatient (Copay is \$100 per surgery)	70% after you pay the Copay

TABLE 3	
Covered Health Services¹	Percentage of Eligible Expenses Payable by the Plan after Annual Deductible is Met:
Diabetes Services <i>See Durable Medical Equipment in Section 6, Details for Covered Health Services, for limits.</i>	
<ul style="list-style-type: none"> ■ Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care 	
- Physician's Office Services	70%
<ul style="list-style-type: none"> ■ Diabetes Self-Management Items 	
- Diabetes equipment	70%
- Diabetes supplies	70%
Durable Medical Equipment (DME)	70%
Emergency Health Services - Outpatient	70%
Family Planning	
<ul style="list-style-type: none"> ■ FDA-approved women's contraception methods, voluntary sterilization and contraceptive counseling 	<i>Network Provider</i> 100% Annual Deductible does not apply <i>Non-Network Provider</i> 70%
<ul style="list-style-type: none"> ■ All other family planning services and supplies 	70%
Habilitation and Rehabilitation Services - Outpatient Therapy (including physical, occupational and speech therapy)	70%
Hearing Aids Maximum Benefits of \$1,000 per ear for any consecutive 36-month period and \$1 per battery.	100% Annual Deductible does not apply
High-Tech Radiology - CT, PET, MRI, MRA and Nuclear Medicine – Outpatient (Copay is \$100 per visit)	70% after you pay the Copay

TABLE 3	
Covered Health Services¹	Percentage of Eligible Expenses Payable by the Plan after Annual Deductible is Met:
Home Health Care	
■ Home infusion therapy	70%
■ All other home health care services	100%
Maximum of 100 visits per Calendar Year.	Annual Deductible does not apply
Hospice Care	70%
	Annual Deductible does not apply
Hospital - Inpatient Stay (Copay is \$150 per day, up to a maximum of \$750 per admission and a maximum of \$2,250 per Calendar Year)	70% after you pay the Copay
Lab, X-Ray and Diagnostics - Outpatient	70%
Mental Health Services	
<i>See Neurobiological Disorders - Autism Spectrum Disorder Services and Serious Mental Illness Services in this section for these Benefits.</i>	
■ Hospital - Inpatient Stay (Copay is \$150 per day, up to a maximum of \$750 per admission and a maximum of \$2,250 per Calendar Year)	70% after you pay the Copay
■ Outpatient Facility Care (Partial Hospitalization/Day Treatment and Intensive Outpatient Treatment)	70%
■ Outpatient Physician or Mental Health Provider Services	70%
Neurobiological Disorders - Autism Spectrum Disorder Services	
■ Hospital - Inpatient Stay (Copay is \$150 per day, up to a maximum of \$750 per admission and a maximum of \$2,250 per Calendar Year)	70% after you pay the Copay
■ Outpatient Facility Care (Partial Hospitalization/Day Treatment and Intensive Outpatient Treatment)	70%
■ Outpatient Physician or Mental Health Provider Services	70%
Nutritional Counseling	70%

TABLE 3	
Covered Health Services¹	Percentage of Eligible Expenses Payable by the Plan after Annual Deductible is Met:
Ostomy Supplies	70%
Pharmaceutical Products – Outpatient Note: Pharmaceutical Products that are preventive in nature are covered as shown under Preventive Care Services in this section. Outpatient prescription medications may be covered under the HealthSelect Prescription Drug Program or the HealthSelect Medicare Rx plan.	70%
Physician Fees for Surgical and Medical Services	70%
Physician's Office Services - Sickness and Injury (including Convenience Care Clinic Services)	70%
Pregnancy – Maternity Services	
<ul style="list-style-type: none"> ■ Physician's Office Services <p>No Coinsurance or Deductible applies to Network prenatal visits or to Network obstetrician delivery services. Complications of Pregnancy are treated as Physician's Office Services - Sickness and Injury.</p>	<p><i>Network Provider</i> 100% Annual Deductible does not apply</p> <p><i>Non-Network Provider</i> 70%</p>
<ul style="list-style-type: none"> ■ Hospital - Inpatient Stay (Copay is \$150 per day, up to a maximum of \$750 per admission and a maximum of \$2,250 per Calendar Year) <p>A separate Copay, Coinsurance and Deductible will not apply for a newborn child unless the child's length of stay in the Hospital exceeds the mother's or unless the mother is not a HealthSelect Plan Participant.</p>	70% after you pay the Copay
<ul style="list-style-type: none"> ■ Physician Fees for Surgical and Medical Services (Non-obstetric services) 	70%
<ul style="list-style-type: none"> ■ Lab, X-Ray and Diagnostics - Outpatient 	<p><i>Network Provider</i> 70%*</p> <p>*If these services are billed by the Provider as preventive, coverage will be at 100% and the Annual Deductible will not apply.</p> <p><i>Non-Network Provider</i> 70%</p>

TABLE 3	
Covered Health Services¹	Percentage of Eligible Expenses Payable by the Plan after Annual Deductible is Met:
<p>Preventive Care Services (See chart on pages 129-130 for list of services.)</p> <p>Note: Under the Affordable Care Act, certain Preventive Care Services are paid at 100% (i.e., at no cost to the Participant) conditioned upon Physician billing and diagnosis. In some cases, you may be responsible for payment on certain related services that are not guaranteed payment at 100% by the Affordable Care Act.</p>	<p><i>Network Provider</i> 100%</p> <p>Annual Deductible does not apply</p> <p><i>Non-Network Provider</i> 70%</p>
Private Duty Nursing - Outpatient	70%
Prosthetic Devices	70%
Reconstructive Procedures	
<ul style="list-style-type: none"> ■ Physician's Office Services 	70%
<ul style="list-style-type: none"> ■ Hospital - Inpatient Stay (Copay is \$150 per day, up to a maximum of \$750 per admission and a maximum of \$2,250 per Calendar Year) 	70% after you pay the Copay
<ul style="list-style-type: none"> ■ Physician Fees for Surgical and Medical Services 	70%
<ul style="list-style-type: none"> ■ Prosthetic Devices 	70%
<ul style="list-style-type: none"> ■ Surgery - Outpatient (Copay is \$100 per surgery) 	70% after you pay the Copay
Rehabilitation Services - Outpatient Therapy (including physical, occupational and speech therapy)	70%
Scopic Procedures - Outpatient Diagnostic and Therapeutic	70%
Serious Mental Illness Services	
<ul style="list-style-type: none"> ■ Hospital - Inpatient Stay (Copay is \$150 per day, up to a maximum of \$750 per admission and a maximum of \$2,250 per Calendar Year) 	70% after you pay the Copay
<ul style="list-style-type: none"> ■ Outpatient Facility Care (Partial Hospitalization/Day Treatment and Intensive Outpatient Treatment) 	70%
<ul style="list-style-type: none"> ■ Outpatient Physician or Mental Health Provider Services 	70%

TABLE 3	
Covered Health Services¹	Percentage of Eligible Expenses Payable by the Plan after Annual Deductible is Met:
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	100% Annual Deductible does not apply
Substance Use Disorder Services	
<ul style="list-style-type: none"> ■ Hospital - Inpatient Stay (Copay is \$150 per day, up to a maximum of \$750 per admission and a maximum of \$2,250 per Calendar Year) 	70% after you pay the Copay
<ul style="list-style-type: none"> ■ Outpatient Facility Care (Partial Hospitalization/Day Treatment and Intensive Outpatient Treatment) 	70%
<ul style="list-style-type: none"> ■ Outpatient Physician or Mental Health Provider Services 	70%
Surgery - Outpatient (Copay is \$100 per surgery)	70% after you pay the Copay
Temporomandibular Joint (TMJ) Services and Orthognathic Surgery	
<ul style="list-style-type: none"> ■ Physician's Office Services 	70%
<ul style="list-style-type: none"> ■ Hospital - Inpatient Stay (Copay is \$150 per day, up to a maximum of \$750 per admission and a maximum of \$2,250 per Calendar Year) 	70% after you pay the Copay
<ul style="list-style-type: none"> ■ Physician Fees for Surgical and Medical Services 	70%
<ul style="list-style-type: none"> ■ Surgery - Outpatient (Copay is \$100 per surgery) 	70% after you pay the Copay
Therapeutic Treatments - Outpatient	70%
Transplant Services	
<ul style="list-style-type: none"> ■ Physician's Office Services 	70%
<ul style="list-style-type: none"> ■ Hospital - Inpatient Stay (Copay is \$150 per day, up to a maximum of \$750 per admission and a maximum of \$2,250 per Calendar Year) 	70% after you pay the Copay
<ul style="list-style-type: none"> ■ Physician Fees for Surgical and Medical Services 	70%
Urgent Care Center Services	70%

TABLE 3	
Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan after Annual Deductible is Met:
Vision Examinations	
<ul style="list-style-type: none"> ■ Routine Eye Exam <p>Maximum of one exam per Participant per Calendar Year.</p>	70%
<ul style="list-style-type: none"> ■ Non-routine or follow-up visits 	70%

¹You must obtain Prior Authorization from UnitedHealthcare, as described in Section 4, *Prior Authorization*, to receive full Benefits before receiving certain Covered Health Services from a Non-Network Provider. In general, if you visit a Network Provider, that Provider is responsible for obtaining Prior Authorization from UnitedHealthcare before you receive certain Covered Health Services. See Section 6, *Details for Covered Health Services*, for further information.

Resource Services for Specific Conditions

This Table 4 describes Covered Health Services available under the Plan that may include resource services for certain conditions when you seek care through UnitedHealthcare's Centers of Excellence (COE) Network. The table contains the percentages of Eligible Expenses that the Plan pays for the resource services listed. The percentage of Eligible Expenses not paid by the Plan is the Coinsurance for which you are responsible. For detailed descriptions of these resource services, refer to *Addendum – Resources to Help you Stay Healthy* under the heading *Resource Services for Specific Conditions*.

TABLE 4	
Covered Health Services	Percentage of Eligible Expenses Payable by the Plan after Annual Deductible is Met:
Cancer Resource Services (CRS)	
<ul style="list-style-type: none"> ■ Hospital - Inpatient Stay (Copay is \$150 per day, up to a maximum of \$750 per admission and a maximum of \$2,250 per Calendar Year) 	70% after you pay the Copay
<ul style="list-style-type: none"> ■ Physician's Office Services 	70%
<ul style="list-style-type: none"> ■ Physician Fees for Surgical and Medical Services 	70%
<ul style="list-style-type: none"> ■ Scopic Procedures - Outpatient Diagnostic and Therapeutic 	70%
<ul style="list-style-type: none"> ■ Surgery - Outpatient (Copay is \$100 per surgery) 	70% after you pay the Copay
<ul style="list-style-type: none"> ■ Therapeutic Treatments - Outpatient 	70%

TABLE 4	
Covered Health Services	Percentage of Eligible Expenses Payable by the Plan after Annual Deductible is Met:
Congenital Heart Disease (CHD) Resource Services	
■ Hospital - Inpatient Stay (Copay is \$150 per day, up to a maximum of \$750 per admission and a maximum of \$2,250 per Calendar Year)	70% after you pay the Copay
■ Physician's Office Services	70%
■ Physician Fees for Surgical and Medical Services	70%
■ Scopic Procedures - Outpatient Diagnostic and Therapeutic	70%
■ Surgery - Outpatient (Copay is \$100 per surgery)	70% after you pay the Copay
Kidney Resource Services (KRS)	
■ Hospital - Inpatient Stay (Copay is \$150 per day, up to a maximum of \$750 per admission and a maximum of \$2,250 per Calendar Year)	70% after you pay the Copay
■ Physician's Office Services	70%
■ Physician Fees for Surgical and Medical Services	70%
■ Scopic Procedures - Outpatient Diagnostic and Therapeutic	70%
■ Surgery - Outpatient (Copay is \$100 per surgery)	70% after you pay the Copay
■ Therapeutic Treatments - Outpatient	70%
Neonatal Resource Services (NRS)	
■ Hospital - Inpatient Stay (Copay is \$150 per day, up to a maximum of \$750 per admission and a maximum of \$2,250 per Calendar Year)	70% after you pay the Copay
■ Physician's Office Services	70%
■ Physician Fees for Surgical and Medical Services	70%
■ Scopic Procedures - Outpatient Diagnostic and Therapeutic	70%

TABLE 4	
Covered Health Services	Percentage of Eligible Expenses Payable by the Plan after Annual Deductible is Met:
■ Surgery - Outpatient (Copay is \$100 per surgery)	70% after you pay the Copay
■ Therapeutic Treatments - Outpatient	70%

SECTION 6 - DETAILS FOR COVERED HEALTH SERVICES

What this section includes:

- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to obtain Prior Authorization from UnitedHealthcare before you receive them, and any reduction in Benefits that may apply if you do not call UnitedHealthcare.

This section supplements Table 3 in Section 5, *Schedule of Benefits and Coverage*.

While Table 3 provides you with the percentage of Eligible Expenses payable by the Plan, along with Benefit limitations, Copayment and Annual Deductible information for each Covered Health Service, this section provides more details of Covered Health Services and the Benefits for them. These details provide any additional limitations that may apply, as well as identify the Covered Health Services for which you must obtain Prior Authorization from UnitedHealthcare. The Covered Health Services in this section appear in the same order as they do in Table 3 for easy reference. Health care services that are not covered are described in Section 7, *Exclusions: What the Medical Plan Will Not Cover*.

Reminders:

All Covered Health Services must be determined by the Plan to be Medically Necessary. Capitalized terms are defined in Section 13, *Glossary*, and may help you to understand the Benefits in this section.

Acquired Brain Injury

The Plan pays Benefits for the treatment of conditions that are the result of, and related to, acquired brain injury. Covered Health Services include, but are not limited to:

- cognitive rehabilitation therapy;
- cognitive communication therapy;
- neurocognitive therapy and rehabilitation;
- neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment;
- neurofeedback therapy;
- remediation;
- post-acute transition services; and
- community reintegration services.

Allergy Treatment

The Plan pays for Benefits for allergy treatment, including injections, testing and antigens/serum, received in a Physician's office or other Outpatient Facility when no other health service is received.

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 13, *Glossary*, for the definition of Emergency and Emergency Health Services.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would seriously jeopardize your life or health. If special circumstances exist, the Plan may pay Benefits for Emergency air transportation to a Hospital that is not the closest Facility to provide Emergency Health Services.

The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as the Plan determines appropriate) between Facilities when the transport is requested by a Physician and is:

- from a Non-Network Hospital to a Network Hospital;
- to a Hospital that provides a higher level of Medically Necessary care that was not available at the original Hospital;
- to a more Cost-Effective acute care Facility; or
- from an acute Facility to a sub-acute setting.

In most cases, UnitedHealthcare will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency air ambulance services, please remember that you must obtain Prior Authorization from UnitedHealthcare as soon as possible prior to the transport. If authorization from UnitedHealthcare is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

Bariatric Surgery

Bariatric surgery is the surgical treatment of obesity provided by or under the direction of a Physician. The Plan covers bariatric surgery provided that all of the following are true:

- you are an active Employee with five continuous years of GBP employment with no breaks in GBP coverage (Benefits for bariatric surgery are not available to Dependents or Retirees);
- you have medical records documenting that you have a minimum of a five-year history of a Body Mass Index (BMI) of 40 or greater; and
- you have one or more conditions considered to be a co-morbidity, uncontrolled even at maximum medical management, and which is generally expected to be reversed or improved by bariatric treatment. Co-morbidities include, but are not limited to:
 - type 2 diabetes;
 - cardiovascular disease (e.g., stroke, myocardial infarction, stable or unstable angina pectoris, hypertension or coronary artery bypass); and
 - life-threatening cardiopulmonary problems (e.g., severe sleep apnea, Pickwickian syndrome, obesity-related cardiomyopathy).

In addition to meeting the above criteria, the following must also be true:

- you have documented active participation in a comprehensive, non-surgical weight reduction program for at least 12 consecutive months during the 24-month period before the date of your request for Prior Authorization for bariatric surgery;

- you have been evaluated by a licensed professional counselor, psychologist, or psychiatrist at least once within the 12 months before the date of your request for Prior Authorization for bariatric surgery; and
- the surgery will be performed at a Bariatric Resource Service (BRS) Center of Excellence by a Network surgeon even if there are no BRS Centers of Excellence near you.

Following the bariatric surgery, you must provide documentation that you have participated in a medically supervised lifestyle management program for maintaining weight loss and healthy lifestyle goals for 12 consecutive months after the date of surgery.

Benefits are available for bariatric surgery services that meet the definition of a Covered Health Service, as defined in Section 13, *Glossary*, and that are not considered Experimental or Investigational or Unproven Services.

Benefits are limited to \$13,000 and one bariatric surgery per lifetime unless there are complications directly resulting from bariatric surgery covered and paid for by the Plan. A separate Bariatric Deductible applies to this Benefit. See Section 3, *How the Plan Works*, for details about this deductible.

Note: Eligible Expenses for bariatric surgery do not apply to the Out-of-Pocket Coinsurance Maximum or to the Total Out-of-Pocket Maximum. Even if these Out-of-Pocket Maximums are met, Eligible Expenses for bariatric surgery will not be paid at 100%. The Copays and Coinsurance shown in Table 3 in Section 5, *Schedule of Benefits and Coverage*, will continue to apply.

Note: The bariatric surgery period is one month before and 12 months following the date of the surgery. Covered Health Services provided by a Physician or other covered health care Provider are allowed under this Benefit for up to 12 months after the date of surgery.

You will have access to a certain Centers of Excellence and Physicians participating in the BRS program, as defined in Section 13, *Glossary*, for bariatric surgery services.

For bariatric surgery services to be considered Covered Health Services under the BRS program, you must contact the BRS program and speak with a nurse consultant and receive Prior Authorization prior to receiving services. You may contact the BRS program by calling toll-free at (888) 936-7246. For more information, go to www.healthselectoftexas.com.

There is no coverage for bariatric surgery that fails to meet all Plan requirements as described in this Bariatric Surgery section or that is not performed by a Network Provider at a Bariatric Resource Service (BRS) Center of Excellence.

Please remember that you must obtain Prior Authorization from Bariatric Resource Services before you have a pre-surgical evaluation. If Prior Authorization from Bariatric Resource Services is not obtained, you will be responsible for paying all charges and no Benefits will be paid by the Plan.

Chiropractic Treatment

The Plan provides Benefits for Chiropractic Treatment when provided by a licensed Doctor of Chiropractic.

Your chiropractor will be required to submit a treatment plan that outlines goal-directed rehabilitation services. Benefits can be denied or limited for Participants who are not progressing

in goal-directed Chiropractic Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance or preventive Chiropractic Treatment.

Benefits for Chiropractic Treatment are limited to \$75 per visit. Benefits for Chiropractic Treatment are limited to 30 visits per Calendar Year.

Christian Science Practitioner Services

Benefits are provided for recognized services of a Christian Science Practitioner when in lieu of Physician or other Provider services.

Clinical Trials

The Plan provides Benefits for routine patient care costs incurred during participation in a qualifying Phase I, II, III or IV Clinical Trial for the prevention, detection or treatment of a life-threatening disease or condition. Benefits are provided for the reasonable and necessary items and services used to prevent, detect and treat complications arising from participation in a qualifying Clinical Trial.

Benefits are available only when the Participant is clinically eligible for participation in the Clinical Trial as defined by the researcher.

Benefits for routine patient care costs for Clinical Trials include, but are not limited to:

- Covered Health Services for which Benefits are typically provided absent a Clinical Trial;
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered Health Services needed for reasonable and necessary care arising from the provision of an investigational item or service.

The following are not considered routine patient care costs for Clinical Trials and no Benefits are payable:

- the Experimental or Investigational Service or item.
- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- items and services associated with managing the Clinical Trial;
- items and services that are inconsistent with widely accepted and established standards of care for the particular diagnosis;
- any item or service that is not a Covered Health Service or is specifically excluded under the Plan, regardless of whether the item or service is required in connection with participation in a Clinical Trial; and
- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

A qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV Clinical Trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and is described in any of the following bullet points:

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - National Institutes of Health (NIH), including the National Cancer Institute (NCI) (including a cancer center that has been designated by the NCI as a Clinical Cancer Center or Comprehensive Cancer Center);
 - Centers for Disease Control and Prevention (CDC);
 - Agency for Healthcare Research and Quality (AHRQ);
 - Centers for Medicare and Medicaid Services (CMS);
 - a cooperative group or center of any of the entities described above, the Department of Defense (DOD) or the Department of Veterans Affairs (VA);
 - a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
 - the Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to both:
 - ◆ be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
 - ◆ assure unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; or
 - an institutional review board of an institution in Texas that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services.
- the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- the Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before Participants are enrolled in the trial. The Plan may, at any time, request documentation about the trial; or
- the subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Congenital Heart Disease (CHD) Services

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician. Benefits include, but are not limited to, the Facility charge and the charge for supplies and equipment. Benefits are available for the following CHD services:

- Outpatient diagnostic testing;
- evaluation;
- surgical interventions;
- interventional cardiac catheterizations (insertion of a tubular device in the heart);
- fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology); and
- in-utero surgery to correct CHD or heart defects.

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks or UnitedHealthcare to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or UnitedHealthcare at (866) 336-9371 toll-free for information about CHD services.

If you receive Congenital Heart Disease services from a Facility that is not a Center of Excellence, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

Additional support services are available when you use a CHD Center of Excellence. See Congenital Heart Disease (CHD) Resource Services under the heading *Resource Services for Specific Conditions in Addendum – Resources to Help you Stay Healthy*.

Please remember that you must obtain Prior Authorization from United Resource Networks or UnitedHealthcare when surgery for CHD will result in an Inpatient Hospital Stay. For Non-Network Benefits, if authorization from United Resource Networks or UnitedHealthcare is not obtained, Benefits for Covered Health Services for the Inpatient Stay will be subject to the \$200 Additional Deductible.

Dental Services

Accident-Related

Dental services are covered by the Plan when all of the following are true:

- treatment is necessary because of accidental damage caused by physical trauma to sound and natural teeth (i.e., teeth with no major restorations and no periodontal involvement) and/or dental work that was in place at the time of the Injury, including, but not limited to, crowns, veneers, bridges and implants;
- the dental damage did not occur as a result of normal activities of daily living or extraordinary use of the teeth;
- dental services are performed by a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and
- the dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the dental damage and if extenuating circumstances exist due to the severity of the accident that caused the dental damage.)

Dental services for final treatment to repair the accidental dental damage must be completed within 24 months of the accident.

The Plan provides Benefits for only the following treatment of accidental dental damage:

- Emergency examination;
- necessary diagnostic X-rays;
- endodontic (root canal) treatment;
- temporary splinting of teeth;
- prefabricated post and core;
- simple minimal restorative procedures (fillings);
- extractions;
- post-traumatic crowns if such are the only clinically acceptable treatment;
- restoration or replacement of dental work that was in place at the time of the Injury, including, but not limited to, crowns, veneers, bridges and implants;
- replacement of lost teeth due to the Injury; and
- temporary repairs immediately following the Injury that will allow any of the above permanent repairs to be performed.

Alternate Benefit for Accident-Related Dental Services

If you require new dental work, such as crowns or implants, or repair/replacement of dental work that was in place at the time of the Injury, as described above, the Plan will pay benefits for the most Cost-Effective procedure(s) recommended by the treating Provider. However, if you choose to have a more costly procedure(s), the Plan may reimburse you for a portion of your costs, up to a maximum of the amount of the more Cost-Effective procedure. When you submit your claim, you must include an estimate from the Provider for the more Cost-Effective procedure(s) in addition to receipts for the alternate procedure(s) actually performed. You will receive a maximum reimbursement of the amount estimated for the more Cost-Effective procedure(s).

Medical Condition-Related

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system);
- treatment or correction of a Congenital Anomaly when provided to an eligible Dependent child; and
- direct treatment of cancer or cleft palate.

The Plan also provides Benefits for Covered Health Services for oral surgery for the following:

- excision of neoplasms, including benign, malignant and premalignant lesions, tumors and non-odontogenic cysts;
- incision and drainage of cellulitis;
- surgical procedures involving sinuses, salivary glands and ducts;
- removal of teeth if integral to a medical procedure prior to radiation therapy of the head and neck, but not the dental reconstruction for the replacement of the extracted teeth;

- replacement of natural teeth lost as a result of radiation therapy performed while you are a Participant in the Plan;
- reconstruction after tumor removal (including bone grafting and dental implants if necessary to stabilize a maxillofacial prosthesis such as an obturator); and
- removal of broken teeth if necessary to reduce jaw fracture.

Dental Anesthesia

The Plan provides Benefits for dental anesthesia for a Participant whose dentist provides documentation that states he or she cannot undergo local anesthesia because of a documented physical, mental or medical reason.

Charges for the dental procedure itself, including, but not limited to, the professional fees of the dentist, are not covered.

Diabetes Services

The Plan pays Benefits for the Covered Health Services identified below.

Covered Diabetes Services	
Diabetic Eye Examinations/Foot Care	Benefits under this section include, but are not limited to, medical eye examinations (dilated retinal examinations) and preventive foot care for Participants with diabetes.
Diabetes Self-Management Training Programs	<p>Benefits are provided for Outpatient self-management training, including, but not limited to:</p> <ul style="list-style-type: none"> ■ training after the initial diagnosis of diabetes regarding the care and management of diabetes, nutritional counseling and proper use of diabetes equipment and supplies; ■ training after a significant diagnosed change in symptoms or condition requiring change in self-management regime; and ■ periodic training warranted by the development of new techniques and treatment for diabetes. <p>These services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.</p>
Diabetic Self-Management Items	<p>Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Participant.</p> <p>Covered diabetes equipment is specifically defined as:</p> <ul style="list-style-type: none"> ■ blood glucose monitors, including monitors designed to be used by blind individuals; ■ insulin pumps and associated appurtenances; ■ insulin infusion devices; and ■ podiatric appliances (shoes, shoe inserts and foot orthotics) for the prevention of complications associated with diabetes.

Covered Diabetes Services	
	<p>Insulin pumps are subject to all the conditions of coverage stated under <i>Durable Medical Equipment</i> in this section.</p> <p>Covered diabetes supplies are specifically defined as:</p> <ul style="list-style-type: none"> ■ test strips for blood glucose monitors; ■ visual reading and urine tests strips; ■ lancets and lancet devices; ■ injection aids; ■ syringes; ■ glucagon emergency kits; and ■ alcohol wipes <p>Note: Insulin, prescriptive and non-prescriptive oral agents for controlling blood sugar levels are covered under the HealthSelect Prescription Drug Program through Caremark or the HealthSelect Medicare Rx plan through SilverScript.</p>

Please remember, to receive Non-Network Benefits you must obtain Prior Authorization from UnitedHealthcare before obtaining any Durable Medical Equipment for the management and treatment of diabetes if the retail purchase cost or cumulative retail rental cost of a single item will exceed \$1,000. To receive Network Benefits you must purchase or rent the DME from the vendor UnitedHealthcare identifies or purchase it directly from the prescribing Network Physician. If authorization from UnitedHealthcare is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- ordered or provided by a Physician for Outpatient use;
- not consumable or disposable;
- used for medical purposes with respect to treatment of a Sickness, Injury or disability or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body (except as noted below); and
- appropriate for use, and primarily used, within the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include, but are not limited to:

- continuous positive airway pressure device (CPAP or BIPAP);
- equipment to administer oxygen (e.g., respirator);
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- negative pressure wound therapy pumps (e.g., wound vacuums);
- burn garments;
- insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- external cochlear devices and systems. (**Note:** Cochlear implants are also covered by the Plan under *Hospital - Inpatient Stay, Rehabilitation Services - Outpatient Therapy or Surgery - Outpatient* in this section);
- cranial remolding orthotics (e.g., cranial helmets);
- braces that stabilize an injured body part, including, but not limited to, necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are excluded from coverage. Dental braces are also excluded from coverage; and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

The Plan also covers batteries, tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period.

Note: DME is different from prosthetic devices – see *Prosthetic Devices* in this section.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every three Calendar Years.

At the Plan's discretion, replacements may be covered when the DME is damaged beyond repair due to normal wear and tear, when repair costs exceed new purchase price or when a replacement piece of DME is required due to the Participant's growth or other physical change or a change in the Participant's abilities or medical condition occurs sooner than the three-year timeframe. Repairs, including, but not limited to, the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three year timeline for replacement.

Please remember, to receive Non-Network Benefits you must obtain Prior Authorization from UnitedHealthcare before obtaining any Durable Medical Equipment if the retail purchase cost or cumulative retail rental cost of a single item will exceed \$1,000. To receive Network Benefits you must purchase or rent the DME from the vendor UnitedHealthcare identifies or purchase it directly from the prescribing Network Physician. If authorization from UnitedHealthcare is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

Emergency Room Services - Outpatient

The Plan's Emergency room services Benefit pays for Outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

If you continue a stay in a Non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, you may be responsible for paying the amount exceeding Eligible Expenses.

Emergency room Benefits may be available when you seek such services to treat a condition you reasonably believe is an Emergency even if, once diagnosed, the condition is not determined by the Plan to have been an Emergency.

Please remember that you or your representative must notify UnitedHealthcare within 48 hours after you are admitted to a Non-Network Hospital as a result of an Emergency. If UnitedHealthcare is not notified, Benefits for the Inpatient Hospital Stay will be subject to the \$200 Additional Deductible.

Family Planning and Infertility Services

The Plan pays Benefits for voluntary family planning services and supplies. Coverage is provided for contraceptive counseling, elective sterilization procedures (tubal ligation or vasectomy), contraceptives drugs administered by a Provider (e.g., Depo-Provera, Norplant) and contraceptive devices (e.g., diaphragm, intrauterine device (IUD)), including fitting and removal.

Note: Oral contraceptives are covered under the HealthSelect Prescription Drug Program through Caremark or the HealthSelect Medicare Rx plan through SilverScript.

Coverage for infertility services includes only diagnostic laboratory and X-ray procedures, therapeutic injections and surgical treatment necessary for the diagnosis and treatment of involuntary infertility (i.e., infertility that is not a result of voluntary sterilization).

For services specifically excluded, refer to Section 7, *Exclusions: What the Medical Plan Will Not Cover*, under the heading *Reproduction/Infertility*.

Habilitation and Rehabilitation Services - Outpatient Therapy

The Plan provides short-term Habilitation services and Outpatient rehabilitation services for the following types of therapy:

- physical therapy;
- occupational therapy;
- speech therapy;
- post-cochlear implant aural therapy;

- cognitive rehabilitation therapy following a traumatic brain Injury or cerebral vascular accident;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

Benefits provided under this section include “Habilitation” services, which are occupational therapy, physical therapy and speech therapy prescribed by a Participant’s treating Physician pursuant to a treatment plan to develop a function not previously developed as a result of a congenital or genetic disorder, or a disorder resulting from Sickness, Injury, trauma or other event or condition suffered by the Participant prior to the development by that Participant of one or more functional life skills such as walking or talking. Benefits for Habilitation services do not apply to Educational services. Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not Habilitation services. When the Participant does not demonstrate continued progress under a treatment plan, a service is no longer a Habilitation service.

To be Covered Health Services, all Habilitation services or rehabilitation services must be performed by a licensed therapy Provider under the direction of a Physician (when required by state law) and must be provided in a Physician's office or on an Outpatient basis at a Hospital or Alternate Facility. Your Provider will be required to submit a treatment plan that outlines goal-directed Habilitation services or rehabilitation services. Benefits can be denied or shortened for Participants who are not progressing in goal-directed Habilitation services or rehabilitation services or if habilitation or rehabilitation goals have previously been met.

Massage therapy is a Covered Health Service when Medically Necessary and provided by a licensed therapy provider, subject to all the conditions of this section.

Except as described below under *Developmental Delay Services*, the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when:

- the speech impediment or dysfunction results from a Congenital Anomaly or Injury or Sickness, including, but not limited to, stroke, cancer or Autism Spectrum Disorder;
- needed following the placement of a cochlear implant; or
- used to treat stuttering, stammering, or other articulation disorders not related to an underlying medical condition.

Benefits can be denied or shortened for Participants who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met.

Developmental Delay Services

The Plan provides Benefits for rehabilitative and Habilitation services for Dependent children with developmental delay that are determined to be necessary to, and provided in accordance with, an individualized family service plan issued by the Interagency Council on Early Childhood Intervention. Covered Health Services include:

- occupational therapy evaluations and services;
- physical therapy evaluations and services; and
- speech therapy evaluations and services.

These services are not subject to any limitations or rehabilitation goal requirements shown in this section.

Hearing Aids

The Plan pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits for hearing aids, including fitting, testing and molds, are limited to \$1,000 per hearing impaired ear for any consecutive 36-month period.

Hearing aid batteries are not included in the hearing aid Benefit limit. Hearing aid batteries are covered at 100% up to maximum of \$1 per battery. When you submit a claim for hearing aid batteries, you must include the receipt and a signed statement confirming that the batteries were purchased for the use in your hearing aid.

Benefits do not include dispensing fees or repairs to a hearing aid, even if the hearing aid purchase was a Covered Health Service under the Plan.

Note: Limited coverage of bone anchored hearing aids is provided as described under *Prosthetic Devices* in this section.

High-Tech Radiology - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

The Plan pays Benefits for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an Outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include, but are not limited to:

- the Facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please remember, to receive Non-Network Benefits, you must obtain Prior Authorization from UnitedHealthcare before scheduled services are received including diagnostic catheterization and electrophysiology implants. If authorization from UnitedHealthcare is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- ordered by a Physician;

- provided by or supervised by a registered nurse (R.N.) or licensed vocational nurse (L.V.N.) , or provided by either a home health aide or licensed practical nurse (L.P.N.) and supervised by a registered nurse, in your home;
- not considered Custodial Care, as defined in Section 13, *Glossary*; and
- provided on a part-time or Intermittent Skilled Nursing Care schedule when Skilled Care is required. Refer to Section 13, *Glossary*, for the definition of Skilled Care.

UnitedHealthcare will decide if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be Skilled Care simply because there is not an available caregiver.

Covered Health Services for home health care include, but are not limited to:

- physical, occupational (when consisting of traditional physical therapy modalities), speech and respiratory therapy services provided by a licensed therapist; and
- supplies and equipment routinely provided by a Home Health Agency.

For services specifically excluded, refer to Section 7, *Exclusions: What the Medical Plan Will Not Cover*, under the heading *Types of Care*.

Benefits under this section are provided for home infusion therapy, which is the administration of fluids, nutrition or medication (including, but not limited to, all additives, and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. There is no coverage for home infusion therapy unless it is performed by a Network Provider.

Home infusion therapy includes, but is not limited to:

- drug and intravenous solutions;
- pharmacy compounding and dispensing services;
- all equipment and ancillary supplies necessitated by the defined therapy;
- delivery services;
- patient and family education; and
- nursing services.

Benefits for home health care are limited to 100 visits per Calendar Year. One visit equals four hours of Skilled Care services.

Please remember, to receive Non-Network Benefits you must obtain Prior Authorization from UnitedHealthcare before receiving services. If authorization from UnitedHealthcare is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill Participant. Hospice care can be provided on an Inpatient or Outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill Participant and short-term grief (bereavement) counseling for immediate family

members while the Participant is receiving Hospice care. Benefits are available only when Hospice care is received from a licensed Hospice, which can include a Hospital.

Benefits for Outpatient Hospice care include, but are not limited to:

- part-time or intermittent nursing care by a registered nurse (R.N.) or licensed vocational nurse (L.V.N.); and
- part-time or intermittent home health aide services that consist primarily of caring for the Participant.

Benefits for Inpatient Hospice care include, but are not limited to:

- all usual nursing care by a registered nurse (R.N.) or licensed vocational nurse (L.V.N.); and
- room and board and all routine services, supplies and equipment provided by the Hospice Facility.

Benefits for Inpatient or Outpatient Hospice care include, but are not limited to:

- physical, occupational (when consisting of traditional physical therapy modalities), speech, and respiratory therapy services provided by a licensed therapist; and
- counseling services by licensed social workers and pastoral counselors routinely provided by the Hospice agency, including bereavement counseling.

For services specifically excluded, refer to Section 7, *Exclusions: What the Medical Plan Will Not Cover*, under the heading *Types of Care*.

Please remember, to receive Non-Network Benefits you must obtain Prior Authorization from UnitedHealthcare before receiving services. If authorization from UnitedHealthcare is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

Hospital - Inpatient Stay

Hospital - Inpatient Stay Benefits are available for:

- non-Physician services and supplies received during an Inpatient Stay;
- room and board in a Semi-private Room; and
- Physician services for radiologists, anesthesiologists, pathologists, assistant surgeons, surgical assistants, consulting Physicians and Emergency room Physicians.

Note: The Plan will pay the difference in cost between a Semi-private Room and a private room only when a Semi-private Room is not available or if a private room is Medically Necessary according to generally accepted medical practice.

Benefits for a Hospital - Inpatient Stay are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

If you are discharged and then readmitted to the Hospital within 24 hours, the Copays you paid for the initial admission are combined with the Copay(s) for the readmission to reach the per-admission maximum.

Example: You are admitted to the Hospital and have an Inpatient Stay of three days, paying a Copay of \$450 (\$150 per day for three days). You are discharged at 5 p.m. on the third day and then readmitted at 8:30 a.m. the following morning and have an Inpatient Stay of four days. You will pay an additional Copay of \$300 (\$150 per day for two days), because that amount is combined with the \$450 Copay to reach the per-admission maximum of \$750.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Room Services* and *Surgery - Outpatient, Scopic Procedures - Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

For scheduled admissions, please remember for Non-Network Benefits, you must obtain Prior Authorization from UnitedHealthcare before you are admitted. If authorization from UnitedHealthcare is not obtained, Benefits will be subject to the \$200 Additional Deductible.

For Emergency admissions (also termed non-scheduled admissions) please remember that you or your representative must notify UnitedHealthcare within 48 hours after you are admitted to a Non-Network Hospital as a result of an Emergency. If UnitedHealthcare is not notified, Benefits for the Inpatient Hospital Stay will be subject to the \$200 Additional Deductible.

Lab, X-Ray and Diagnostics - Outpatient

Covered Health Services for Sickness and Injury-related diagnostic purposes, received on an Outpatient basis at a Hospital or Alternate Facility include, but are not limited to:

- lab and radiology/X-ray;
- mammography; and
- bone density screening.

Benefits under this section include, but are not limited to:

- the Facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *High-Tech Radiology - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

Please remember, to receive Non-Network Benefits for sleep studies, you must obtain Prior Authorization from UnitedHealthcare before scheduled services are received. If authorization from UnitedHealthcare is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

Mental Health Services

The Plan pays Benefits for Mental Health Services for the treatment of Mental Illness received on an Inpatient or Outpatient basis in a Hospital, an Alternate Facility or in a Provider's office. Services must be received from a Mental Health Provider as defined in Section 13, *Glossary*.

Note: Benefits for Serious Mental Illness, as defined in Section 13, *Glossary*, will be paid at the same level as Benefits for any other condition, Sickness or Injury. See *Serious Mental Illness Services* in this section and in Section 5, *Schedule of Benefits and Coverage*.

Covered Health Services include, but are not limited to, the following services:

- individual or group psychotherapy;
- psychodynamic therapy;
- mental health counseling;
- electroconvulsive treatment;
- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- psychotropic drugs, including their administration;
- medication management;
- individual, family, therapeutic group and Provider-based case management services;
- crisis intervention;
- services at a Residential Treatment Facility;
- psychological testing and assessment;
- Partial Hospitalization/Day Treatment; and
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Note: The Plan will pay the difference in cost between a Semi-private Room and a private room only when a Semi-private Room is not available or if a private room is Medically Necessary according to generally accepted medical practice.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for Referrals to Providers and coordination of care. Inpatient Mental Health Services must be authorized and overseen by the Mental Health/Substance Use Disorder Administrator.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Mental Health Services benefit. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Participant and is not mandatory.

Please remember for Non-Network Benefits, you must obtain Prior Authorization from the Mental Health/Substance Use Disorder Administrator to receive Inpatient Benefits. When you obtain Prior Authorization, the Mental Health/Substance Use Disorder Administrator will work with you to determine the appropriate setting for your treatment. Please refer to Section 4, *Prior Authorization*, for the specific services that require notification. Please call (866) 336-9371 toll-free. Without Prior Authorization Covered Health Services for the Inpatient Stay will be subject to the \$200 Additional Deductible.

For Emergency admissions (also termed non-scheduled admissions) please remember that you or your representative must notify the Mental Health/Substance Use Disorder Administrator within 48 hours after you are admitted to a Non-Network Facility as a result of an Emergency. If the Mental Health/Substance Use Disorder Administrator is not notified, Benefits for the Inpatient Hospital Stay will be subject to the \$200 Additional Deductible.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for psychiatric services for Autism Spectrum Disorders (otherwise known as neurodevelopmental disorders) that are both of the following:

- provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric Provider; and
- focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impair daily functioning.

These Covered Health Services include only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section and subject to the terms and limitations of the Plan.

Covered Health Services include, but are not limited to, the following services provided on either an Outpatient or Inpatient basis:

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and Provider-based case management services;
- crisis intervention;
- services at a Residential Treatment Facility;
- Partial Hospitalization/Day Treatment; and
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Note: The Plan will pay the difference in cost between a Semi-private Room and a private room only when a Semi-private Room is not available or if a private room is Medically Necessary according to generally accepted medical practice.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for Referrals to Providers and coordination of care. Inpatient Mental Health Services for Autism Spectrum Disorders must be authorized and overseen by the Mental Health/Substance Use Disorder Administrator.

Please remember for Non-Network Benefits, you must obtain Prior Authorization from the Mental Health/Substance Use Disorder Administrator to receive Inpatient Benefits. When you obtain Prior Authorization, the Mental Health/Substance Use Disorder Administrator will work with you to determine the appropriate setting for your treatment. Please refer to Section 4, *Prior Authorization*, for the specific services that require notification. Please call (866) 336-9371 toll-free. Without Prior Authorization Covered Health Services for the Inpatient Stay will be subject to the \$200 Additional Deductible.

For Emergency admissions (also termed non-scheduled admissions) please remember that you or your representative must notify the Mental Health/Substance Use Disorder Administrator within 48 hours after you are admitted to a Non-Network Facility as a result of an Emergency. If the Mental Health/Substance Use Disorder Administrator is not notified, Benefits for the Inpatient Hospital Stay will be subject to the \$200 Additional Deductible.

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office or Inpatient setting by an appropriately licensed or health care professional when:

- medical education services are required for a disease in which patient self-management is an important component of treatment; and
- there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Some examples of such medical conditions include, but are not limited to:

- diabetes;
- coronary artery disease;
- congestive heart failure;
- severe obstructive airway disease;
- gout (a form of arthritis);
- renal failure;
- phenylketonuria (a genetic disorder diagnosed at infancy); and
- hyperlipidemia (excess of fatty substances in the blood).

Nutritional counseling services include, but are not limited to, the education, counseling, or training of a Participant regarding diet, regulation or management of diet or the assessment or management of nutrition.

In addition, the Plan provides Benefits for dietary or nutritional evaluations for Participants with developmental delay that are determined to be necessary to, and provided in accordance with, an individualized family service plan issued by the Interagency Council on Early Childhood Intervention.

Ostomy Supplies

Benefits for ostomy supplies include, but are not limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters;
- skin barriers; and
- deodorants, filters, lubricants, tape, appliance cleaners, adhesive and adhesive remover.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an Outpatient basis in a Hospital, Alternate Facility or Physician's office. The Plan also pays for Pharmaceutical Products that are administered in a Participant's home but only by a Network Provider. Examples of what would be included under this category are antibiotic injections in the Physician's office, inhaled medication in an Urgent Care Center for treatment of an asthma attack or Medically Necessary growth hormone therapy.

Benefits under this section are provided only for Pharmaceutical Products that, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified Provider or licensed/certified health professional, unless approved for self-administration by the United States Food and Drug Administration (FDA).

Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy under the HealthSelect Prescription Drug Program through Caremark or the HealthSelect Medicare Rx plan through SilverScript. Additional information for the HealthSelect Prescription Drug Program is located at <http://www.caremark.com/ers/>. More information on the HealthSelect Medicare Rx plan is located at <http://hsmedicarerx.com>.

Physician Fees for Surgical and Medical Services

The Plan pays Benefits for Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility, or for Physician house calls.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services received in a Physician's office for the evaluation, diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital. Benefits under this section include, but are not limited to, allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing that is determined to be Medically Necessary following genetic counseling when ordered by the Physician and authorized in advance by UnitedHealthcare.

Covered Health Services also include Telehealth and Telemedicine services, such as the use of electronic media for diagnosis, consultation, treatment, transfer of medical data and medical education.

Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office. Benefits for high-tech radiology such as CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *High-Tech Radiology - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

Benefits for preventive services are described under *Preventive Care Services* in this section.

Please remember, to receive Non-Network Benefits for Genetic Testing – BRCA (breast cancer gene) you must obtain Prior Authorization from UnitedHealthcare. If authorization from UnitedHealthcare is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

Please Note

Your Physician does not have a copy of your MBPD, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

The Plan provides Benefits for Covered Health Services related to Pregnancy. Covered Health Services include, but are not limited to, all maternity-related medical services for prenatal care, postnatal care, delivery services provided by the delivering Physician, laboratory tests, sonograms, stress tests, amniocentesis and expenses for the Hospital – Inpatient Stay, including assistant surgeon or anesthesiologist fees if required. Benefits to treat any related Complications of Pregnancy will be paid at the same level as Benefits for any other medical condition, Sickness or Injury.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery; or
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The Hospital or other Provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Participants in the immediate family. Covered Health Services include related tests and treatment.

Please remember for Non-Network Benefits, you must obtain Prior Authorization from UnitedHealthcare as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above. If authorization from UnitedHealthcare is not obtained, Benefits for the extended stay will be subject to the \$200 Additional Deductible.

Note: If the newborn remains hospitalized after the mother is released, in order to ensure that a penalty is not applied, you should obtain separate Prior Authorization for the child and arrange to have the child admitted to the Hospital in his or her own name for treatment by a Physician or other Provider for the non-routine services.

Healthy moms and babies

The Plan offers, through UnitedHealthcare, a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See the *Resources to Help you Stay Healthy Addendum*, for details.

Preventive Care Services

The Plan pays Benefits for Preventive care services provided on an Outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- evidence-based items or services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- immunizations that have a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the federal Health Resources and Services Administration; and
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the federal Health Resources and Services Administration.

Preventive care services described in this section are those that are relevant for implementing the Affordable Care Act to the extent required by applicable law, and as it may be amended, and subject to determination and interpretation by the Plan.

Preventive Services that are currently rated as A or B according to the United States Preventive Services Task Force (USPSTF) are listed in *Addendum - List of Covered Preventive Care Services*. This list is subject to change according to the guidelines and recommendation provided by USPSTF as determined by the Plan. Coverage is subject to guidelines based on age, dosage, and frequency.

Note: If the preventive care guidelines include an annual limit, the limit will apply on a Calendar Year basis.

Breastfeeding

The Plan provides Benefits for lactation support and counseling sessions for female Participants in conjunction with childbirth. Benefits are limited to three sessions per childbirth. To be

considered Covered Health Services, services must be received from a Network Provider and/or Facility.

Preventive care Benefits defined under the federal Health Resources and Services Administration requirement provide for the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. You may purchase a breast pump from a Network DME Provider or Physician. You may also purchase a breast pump at a retail location and submit a claim as described in Section 8, *Claims Procedures*. Benefits for breast pumps are provided at 100% of Eligible Expenses.

Breast pumps are available only within 30 days of the baby's estimated delivery date. You or your Provider should indicate on your claim the estimated date.

Note: Rental of breast pumps and any shipping costs related to purchase or rental of a breast pump are not Covered Health Services under this Benefit.

For questions about your preventive care Benefits under this Plan call (866) 336-9371 toll-free.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care when ordered and provided under the direction of a Physician and given on an Outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.).

Benefits are available when Skilled Care is needed and nursing intervention is required at least every two to three hours and when one or more of the following is true:

- the Participant's condition makes him or her homebound; or
- the Participant's condition plus the geographic distance make it unreasonable for him or her to obtain the needed services in an Outpatient Facility or Physician's office; or
- the Participant's condition makes him or her technology dependent;
- services are needed on a continuous basis (e.g., suctioning or hemodynamic monitoring) to assure immediate intervention if required; or
- the services are more Cost-Effective in the home than an alternative setting.

The Participant's treatment plan should be reviewed periodically (no less than every 60 days, or as determined by the Plan) and updated by the Physician.

Benefits are provided for the time devoted to providing the Participant with services that are Medically Necessary.

Please remember, to receive Non-Network Benefits you must obtain Prior Authorization from UnitedHealthcare before receiving services. If authorization from UnitedHealthcare is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

Prosthetic Devices

Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- artificial arms, legs, feet and hands;

- artificial face, eyes, ears and nose; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are also provided for bone anchored hearing aids only for Participants who have either of the following:

- craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Note: Procedures related to covered bone anchored hearing aids are also covered by the Plan under *Hospital - Inpatient Stay* or *Surgery - Outpatient* in this section.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

At the Plan's discretion, replacements may be covered when the prosthetic device is damaged beyond repair due to normal wear and tear, when repair costs are less than the cost of replacement or when a replacement prosthetic device is required due to the Participant's growth or other physical change or a change in the Participant's abilities or medical condition. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Please remember, to receive Non-Network Benefits you must obtain Prior Authorization from UnitedHealthcare before obtaining any prosthetic device that exceeds \$1,000 in cost per device. If authorization from UnitedHealthcare is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part, not primarily changing or improving physical appearance of a healthy organ or body part. Reconstructive procedures include surgery or other procedures that are associated with an Injury, Sickness or Congenital Anomaly.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the Women's Health and Cancer Rights Act of 1998, including, but not limited to, breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at (866) 336-9371 toll-free for more information about Benefits for mastectomy-related services.

When the purpose of a procedure is to improve the appearance of a healthy body part, it is a Cosmetic Procedure and it is excluded from coverage under the Plan. For Participants age 19 and over, procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 13, *Glossary*.

The fact that a Participant may suffer negative psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery to address the condition (or other procedures done to relieve such consequences or behavior) as a covered reconstructive procedure.

For Participants under the age of 19, reconstructive procedures that improve the function of, or attempt to create a normal appearance of, an abnormal structure caused by a Congenital Anomaly, development deformity, trauma, tumor, infection or disease are not considered Cosmetic Procedures and are Covered Health Services under the Plan.

For scheduled admissions for Reconstructive Procedures, please remember for Non-Network Benefits, you must obtain Prior Authorization from UnitedHealthcare before you are admitted. If authorization from UnitedHealthcare is not obtained, Benefits will be subject to the \$200 Additional Deductible.

For a non-scheduled Reconstructive Procedure, please remember that you or your representative must notify UnitedHealthcare within 48 hours after you are admitted to a Non-Network Hospital. If UnitedHealthcare is not notified, Benefits for the Inpatient Hospital Stay will be subject to the \$200 Additional Deductible and Benefits will be paid at the Non-Network level.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays Benefits for diagnostic and therapeutic scopic procedures and related services received on an Outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are minimally invasive medical examinations that enable visualization, performance of biopsies and polyp removal. Examples of diagnostic scopic procedures include, but are not limited to, colonoscopy, sigmoidoscopy, and endoscopy. Therapeutic scopic procedures are usually surgical in nature. Examples of therapeutic scopic procedures include, but are not limited to, bronchoscopy and esophagoscopy.

Benefits under this section include, but are not limited to:

- the Facility charge and the charge for supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include, but are not limited to, arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

Serious Mental Illness Services

Benefits for the Medically Necessary treatment of Serious Mental Illness, as defined in Section 13, *Glossary*, will be paid at the same level as Benefits for any other condition, Sickness or Injury.

The Plan pays Benefits for Covered Health Services received on an Inpatient or Outpatient basis in a Hospital, an Alternate Facility or in a Provider's office. Services must be received from a Physician or a Mental Health Provider as defined in Section 13, *Glossary*.

Covered Health Services include, but are not limited to, the following services:

- individual or group psychotherapy;
- psychodynamic therapy;
- mental health counseling;
- electroconvulsive treatment;
- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- psychotropic drugs, including their administration;
- medication management;
- individual, family, therapeutic group and Provider-based case management services;
- crisis intervention;
- services at a Residential Treatment Facility;
- psychological testing and assessment;
- Partial Hospitalization/Day Treatment; and
- Intensive Outpatient Treatment.

Covered Health Services also include transcranial magnetic stimulation (TMS) provided on an Outpatient basis for an adult patient with a major depressive disorder that is a Serious Mental Illness that has not been responsive to other Medically Necessary treatments.

The Mental Health/Substance Use Disorder Administrator, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Note: The Plan will pay the difference in cost between a Semi-private Room and a private room only when a Semi-private Room is not available or if a private room is Medically Necessary according to generally accepted medical practice.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for Referrals to Providers and coordination of care. Inpatient Mental Health Services must be authorized and overseen by the Mental Health/Substance Use Disorder Administrator.

Please remember for Non-Network Benefits, you must obtain Prior Authorization from the Mental Health/Substance Use Disorder Administrator to receive Inpatient Benefits. When you obtain Prior Authorization, the Mental Health/Substance Use Disorder Administrator will work with you to determine the appropriate setting for your treatment. Please refer to Section 4, *Prior Authorization*, for the specific services that require notification. Please call (866) 336-9371 toll-free. Without Prior Authorization Covered Health Services for the Inpatient Stay will be subject to the \$200 Additional Deductible.

For Emergency admissions (also termed non-scheduled admissions) please remember that you or your representative must notify the Mental Health/Substance Use Disorder Administrator within 48 hours after you are admitted to a Non-Network Facility as a result of an Emergency. If the Mental Health/Substance Use Disorder Administrator is not notified, Benefits for the Inpatient Hospital Stay will be subject to the \$200 Additional Deductible.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

The Plan pays Benefits for Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits include, but are not limited to:

- non-Physician services and supplies received during the Inpatient Stay;
- room and board in a Semi-private Room; and
- Physician services for radiologists, anesthesiologists and pathologists.

Note: The Plan will pay the difference in cost between a Semi-private Room and a private room only when a Semi-private Room is not available or if a private room is Medically Necessary according to generally accepted medical practice.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

The Plan will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if:

- the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost-Effective alternative to an Inpatient Stay in a Hospital; and
- the Skilled Care services to be provided are not primarily Custodial Care.

You are expected to improve to a predictable level of recovery. Your Provider will be required to submit a treatment plan that outlines goal-directed rehabilitation services. Benefits can be denied or shortened for Participants who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 13, *Glossary*.

For scheduled admissions, please remember, to receive Non-Network Benefits you must obtain Prior Authorization from UnitedHealthcare before you are admitted. If authorization from UnitedHealthcare is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

For Emergency admissions (also termed non-scheduled admissions) please remember that you or your representative must notify UnitedHealthcare within 48 hours after you are admitted to a Non-Network Facility as a result of an Emergency. If UnitedHealthcare is not notified, you will be responsible for paying all charges and no Benefits will be paid.

Substance Use Disorder Services

The Plan pays Benefits for Substance Use Disorder Services (also known as substance-related and addictive disorders services) received on an Inpatient or Outpatient basis in a Hospital, an Alternate Facility or in a Provider's office.

Covered Health Services include, but are not limited to, the following services:

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and Provider-based case management services;
- crisis intervention;
- detoxification (sub-acute/non-medical);
- services at a Residential Treatment Facility;
- Partial Hospitalization/Day Treatment; and
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Note: The Plan will pay the difference in cost between a Semi-private Room and a private room only when a Semi-private Room is not available or if a private room is Medically Necessary according to generally accepted medical practice.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for Referrals to Providers and coordination of care. Inpatient Substance Use Disorder Services must be authorized and overseen by the Mental Health/Substance Use Disorder Administrator.

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Substance Use Disorder Services benefit. Special programs or services provide access to services that are beneficial for the treatment of your substance-related and addictive disorder which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Participant and is not mandatory.

Please remember for Non-Network Benefits, you must obtain Prior Authorization from the Mental Health/Substance Use Disorder Administrator to receive Inpatient Benefits. When you obtain Prior Authorization, the Mental Health/Substance Use Disorder Administrator will work with you to determine the appropriate setting for your treatment. Please refer to Section 4, *Prior Authorization*, for the specific services that require notification. Please call (866) 336-9371 toll-free. Without Prior Authorization Covered Health Services for the Inpatient Stay will be subject to the \$200 Additional Deductible.

For Emergency admissions (also termed non-scheduled admissions) please remember that you or your representative must notify the Mental Health/Substance Use Disorder Administrator within 48 hours after you are admitted to a Non-Network Facility as a result of an Emergency. If the Mental Health/Substance Use Disorder Administrator is not notified, Benefits for the Inpatient Hospital Stay will be subject to the \$200 Additional Deductible.

Surgery - Outpatient

The Plan provides Benefits for surgery and related services received on an Outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Covered Health Services under this section include, but are not limited to:

- surgery and related services;
- the Facility charge and the charge for supplies and equipment;
- certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy); and
- Physician services for radiologists, anesthesiologists and pathologists.

Examples of surgical procedures performed in a Physician's office include, but are not limited to, mole removal and ear wax removal.

Please remember, to receive Non-Network Benefits for cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators and sleep apnea surgeries you must obtain Prior Authorization from UnitedHealthcare before scheduled services are received or, for non-scheduled services, within 48 hours or as soon as is reasonably possible. If authorization from UnitedHealthcare is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

Temporomandibular Joint (TMJ) Services and Orthognathic Surgery

The Plan pays Benefits for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes, but is not limited to, necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.

Covered diagnostic treatment includes, but is not limited to, examination, radiographs and applicable imaging studies and consultation.

Benefits are provided for surgical treatment if:

- there is clearly demonstrated radiographic evidence of significant joint abnormality;
- non-surgical treatment has failed to adequately resolve the symptoms; and
- pain or dysfunction is moderate or severe.

Benefits for surgical services include, but are not limited to, arthroscopy, arthroplasty, arthrotomy and open or closed reduction of dislocations. Benefits also include oral surgery to reduce a dislocation of, excisions of and injection of the temporomandibular joint.

The Plan also provides Benefits for orthognathic surgery.

Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under *Hospital – Inpatient Stay* and *Physician Fees for Surgical and Medical Services*, respectively.

Please remember for Non-Network Benefits, you must obtain Prior Authorization from UnitedHealthcare before orthognathic surgery is performed on an Inpatient basis. If authorization from UnitedHealthcare is not obtained, Benefits for the Inpatient Stay will be subject to the \$200 Additional Deductible.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an Outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including, but not limited to, dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an Outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered health care professionals when:

- education is required for a disease in which patient self-management is an important component of therapeutic treatment; and
- there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services under this section include, but are not limited to:

- the Facility charge and the charge for related supplies and equipment; and

- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please remember, to receive Non-Network Benefits you must obtain Prior Authorization from UnitedHealthcare for all outpatient therapeutic treatments before scheduled services are received or, for non-scheduled services, within 48 hours or as soon as is reasonably possible. If authorization from UnitedHealthcare is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

Transplant Services

The Plan pays Benefits for transplant services only if Inpatient Facility services (including, but not limited to, evaluation for transplant, organ procurement and donor searches) for transplant procedures are ordered by a Physician. Benefits are available to the donor and the recipient when the recipient is covered under this Plan. If the recipient is not a Participant in this Plan but the donor is a Participant in this Plan, then the recipient's plan is the Primary Plan and this Plan is the Secondary Plan for the donor's expenses in all cases, regardless of coordination of benefits rules to the contrary. The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Examples of transplants for which Benefits are available include, but are not limited to:

- heart;
- heart/lung;
- lung;
- kidney;
- kidney/pancreas;
- liver;
- liver/kidney;
- liver/intestinal;
- pancreas;
- intestinal; and
- bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service.

Benefits are also available for cornea transplants. However, you are not required to obtain Prior Authorization from United Resource Networks or UnitedHealthcare for a cornea transplant.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan or through the donor's coverage under this Plan with the recipient's plan being the Primary Plan and this Plan being the Secondary Plan.

The Plan has specific guidelines regarding Benefits for transplant services. Contact United Resource Networks at (888) 936-7246 toll-free or UnitedHealthcare at (866) 336-9371 toll-free for information about these guidelines.

Please remember that you must obtain Prior Authorization from United Resource Networks or UnitedHealthcare as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If authorization from United Resource Networks or UnitedHealthcare is not obtained, Benefits for an Inpatient Stay will be subject to the \$200 Additional Deductible.

Support in the event of serious illness

If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country. Please call UnitedHealthcare at (866) 336-9371 toll-free.

Urgent Care Center Services

The Plan provides Benefits for professional services received at an Urgent Care Center, as defined in Section 13, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section.

Vision Examinations

The Plan pays Benefits for:

- vision screenings, which could be performed as part of an annual physical examination in a Provider's office (vision screenings do not include refractive examinations to detect vision impairment);
- one routine eye exam, including, but not limited to, refraction and glaucoma screening, to detect vision impairment by a Provider in the Provider's office every Calendar Year. Routine eye exams do not include contact lens exams; and
- non-routine or follow-up visits.

SECTION 7 - EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Details for Covered Health Services*.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Details for Covered Health Services*, those limits are reflected in the corresponding Covered Health Service category in Section 5, *Schedule of Benefits and Coverage*. Additional limits may apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, *Schedule of Benefits and Coverage*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed the Benefit limits.

Please note that in listing services or examples, when the MBPD says "this includes," or "including, but not limited to," it is not the Plan's intent to limit the items to that specific list. When the Plan does intend to limit a list of services or examples, the MBPD specifically states that the list is limited to or covers only the specific items listed.

The Plan does not pay Benefits for the excluded services, treatments or supplies even if they are recommended or prescribed by a Provider, are the only available treatment for your condition or are determined by the Plan to be Medically Necessary. You are solely responsible for payment of charges for all services and supplies excluded by the Plan and described in this section.

The following services, treatments and supplies are excluded from coverage under the Plan:

Alternative Treatments

1. acupressure.
2. acupuncture.
3. aromatherapy.
4. hypnotism.
5. massage therapy except as described under *Rehabilitation Services - Outpatient Therapy* in Section 6, *Details for Covered Health Services*.
6. Rolfing (holistic tissue massage).
7. art therapy, music therapy, dance therapy, horseback therapy, wilderness experience therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Chiropractic Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, *Details for Covered Health Services*.

Dental

1. dental care, including, but not limited to, endodontics, periodontal surgery and restorative treatment, except as identified under *Dental Services* in Section 6, *Details for Covered Health Services*.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. An example of what is not covered is treatment of dental caries resulting from dry mouth due to radiation treatment or medication.

2. diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include, but are not limited to:
 - extractions (including, but not limited to, wisdom teeth);
 - restoration and replacement of teeth;
 - medical or surgical treatments of dental conditions; and
 - services to improve dental clinical outcomes.

This exclusion does not apply to dental services for which Benefits are provided as described under *Dental Services* in Section 6, *Details for Covered Health Services*.

3. dental implants, bone grafts, and other implant-related procedures.

This exclusion does not apply to dental services for which Benefits are provided as described under *Dental Services* in Section 6, *Details for Covered Health Services*.

4. dental braces (orthodontics).

5. dental X-rays, supplies and appliances and all associated expenses, including, but not limited to, hospitalizations and anesthesia.

This exclusion does not apply to:

- dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition; or
- hospitalization and anesthesia for certain Participants who cannot undergo local anesthesia

for which Benefits are available under the Plan, as described in Section 6, *Details for Covered Health Services*.

6. treatment of malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

1. devices used specifically as safety items or to affect performance in sports-related activities.
2. orthotic appliances and devices that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* in Section 6, *Details for Covered Health Services*:

Examples of excluded orthotic appliances and devices include, but are not limited to, foot orthotics or any orthotic braces available over-the-counter. This exclusion does not include podiatric appliances for the prevention of complications associated with diabetes as described under *Diabetes Services* in Section 6, *Details for Covered Health Services*.

3. the following items are excluded, even if prescribed by a Physician:
 - blood pressure cuff/monitor;
 - enuresis alarm;
 - non-wearable external defibrillator;
 - trusses; and
 - ultrasonic nebulizers.
4. the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect.
5. the replacement of lost or stolen prosthetic devices.
6. devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Details for Covered Health Services*.
7. oral appliances for snoring.

Drugs

1. prescription drugs for Outpatient use that are filled by a prescription order or refill.
Note: Outpatient prescription medications are covered under the HealthSelect Prescription Drug Program through Caremark or the HealthSelect Medicare Rx plan through SilverScript. For more information on covered Outpatient use prescription medications for the HealthSelect Prescription Drug Program through Caremark, go to <http://www.caremark.com/ers>. For more information on covered Outpatient use prescription medications for the HealthSelect Medicare RX plan through SilverScript, go to <http://hsmedicarerx.com>.
2. self-injectable medications, except as described under *Pharmaceutical Products* in Section 6, *Details for Covered Health Services*.

(This exclusion does not apply to medications which, due to their characteristics, as determined by the Plan, must typically be administered or directly supervised by a qualified Provider or licensed/certified health professional in an Outpatient setting). **Note:** Insulin is an Outpatient prescription medication covered under the HealthSelect Prescription Drug Program through Caremark or the HealthSelect Medicare Rx plan through SilverScript.
3. growth hormone therapy that is not Medically Necessary.
4. non-injectable medications given in a Physician's office except as required in an Emergency and consumed in the Physician's office.
5. over-the-counter drugs and treatments.

Educational Services

1. Services that are Educational in nature, as defined in Section 13, *Glossary*.

This exclusion does not apply to Diabetes Self-Management Training Programs for which Benefits are provided as described under *Diabetes Services* in Section 6, *Details for Covered Health Services*.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services or Unproven Services, as described in Section 13, *Glossary*.

This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Details for Covered Health Services*.

Foot Care

1. routine foot care services that include, but are not limited to:

- cutting or removal of corns and calluses;
- nail trimming or cutting; and
- debriding (removal of dead skin or underlying tissue).

This exclusion does not apply to foot care for severe systemic disease or preventive foot care for Participants with diabetes for which Benefits are provided as described under *Diabetes Services* in Section 6, *Details for Covered Health Services*.

2. hygienic and preventive maintenance foot care, except for Participants who are at risk of neurological or vascular disease arising from diseases such as diabetes. Examples include, but are not limited to:

- cleaning and soaking the feet; and
- applying skin creams in order to maintain skin tone; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.

3. treatment of flat feet.
4. treatment of subluxation of the foot.
5. arch supports.
6. shoe inserts, shoes (standard or custom), lifts and wedges and shoe orthotics.

This exclusion does not include podiatric appliances for the prevention of complications associated with diabetes as described under *Diabetes Services* in Section 6, *Details for Covered Health Services*.

Medical Supplies and Equipment

1. prescribed or non-prescribed medical and disposable supplies. Examples of excluded supplies include, but are not limited to: compression stockings, ace bandages and wound care or dressing supplies purchased over the counter.

This exclusion does not apply to:

- ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Details for Covered Health Services*;

- disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Details for Covered Health Services*;
 - urinary catheters;
 - wound care or dressing supplies given by a Provider during treatment for Covered Health Services;
 - medical-grade compression stockings when considered Medically Necessary. The stockings must be prescribed by a Physician, individually measured and fitted to the patient; and
 - diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, *Details for Covered Health Services*.
2. batteries, tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment.
 3. the repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect.
 4. the replacement of lost or stolen Durable Medical Equipment.

Mental Health/Substance Use Disorder Services

In addition to all other exclusions listed in this Section 7, *Exclusions*, the exclusions listed directly below apply to services described under *Mental Health Services*, *Neurobiological Disorders - Autism Spectrum Disorder Services*, *Serious Mental Illness Services* and/or *Substance Use Disorder Services* in Section 6, *Details for Covered Health Services*.

1. services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. health services or supplies that do not meet the definition of a Covered Health Service - see the definition in Section 13, *Glossary*.
3. Mental Health Services as treatments for R-, T- and Z-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
4. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, sexual dysfunction disorders, feeding disorders, binge eating disorders, neurological disorders and other disorders with known physical bases.
5. treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorders.
6. tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.
7. learning, motor disorders and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
8. treatment for intellectual disability as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

9. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
10. all unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
11. methadone treatment, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction. **Note:** These may be covered under the HealthSelect Prescription Drug Program through Caremark or the HealthSelect Medicare Rx plan through SilverScript.
12. services, supplies and related expenses that the Plan determines to be Educational in nature, unless expressly covered under the Plan.
13. intensive behavioral therapies such as Applied Behavioral Analysis for Autism Spectrum Disorders.
14. any treatments or other specialized services designed for Autism Spectrum Disorder that are not supported by credible research demonstrating that the treatments or services have a measurable and beneficial health outcome and therefore are considered to be Educational in nature, or to be Experimental or Investigational or Unproven Services.
15. Services for any family, marital or other relational disorder or condition, except in the case of Marriage and Family Therapy/Counseling as defined in Section 13, *Glossary*, as required under a Participant's Physician-directed treatment plan for a specific disease or condition.
16. self-treatment by a provider as a part of their training; treatment by an individual or facility outside the scope of licensed or otherwise authorized scope of practice.
17. Medical Social Services provided as mental health or substance-related and addictive disorder treatment. This exclusion does not apply to Medical Social Services provided as part of Physician-ordered treatment provided for home health care, Hospice care or Private Duty Nursing or provided while you are confined in a Skilled Nursing or Inpatient Rehabilitation Facility.
18. vocational counseling.

Nutrition

1. nutritional or cosmetic therapy using high doses or mega quantities of vitamins, minerals or elements, and other nutrition based therapy.
2. nutritional counseling for either individuals or groups, except as identified under *Diabetes Services*, under *Developmental Delay Services* and under *Nutritional Counseling* in Section 6, *Details for Covered Health Services*.
3. enteral formulas and other nutritional and electrolyte formulas, including, but not limited to, infant formula and donor breast milk (infant formula available over-the-counter is always excluded) and home infusion therapy for over-the-counter fluids that do not require a prescription, including, but not limited to, standard nutritional formulations used for enteral nutrition therapy.

This exclusion does not apply to:

- enteral feedings or other nutritional formulas that are the only source or the majority of nutrition or that are specifically created to treat inborn errors of metabolism or heritable diseases such as phenylketonuria (PKU);
 - Medically Necessary amino-acid based elemental formulas that are used for the diagnosis and treatment of:
 - ◆ immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
 - ◆ severe food protein-induced enterocolitis syndrome;
 - ◆ eosinophilic disorders, as evidenced by a biopsy; or
 - ◆ impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.
4. food of any kind. Examples include, but are not limited to:
- high-protein, low-protein or low-carbohydrate foods;
 - foods to control weight, treat obesity (including, but not limited to, liquid diets), lower cholesterol or control diabetes;
 - oral vitamins and minerals;
 - meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
 - other dietary, nutritional and electrolyte supplements.
5. health education classes unless offered by UnitedHealthcare or its affiliates, including, but not limited to, asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. television.
2. telephone.
3. beauty/barber service.
4. guest service.
5. health club membership and programs.
6. breast pumps except as Benefits are provided under the federal Health Resources and Services Administration (HRSA) requirement as described under *Preventive Care Services* in Section 6, *Details for Covered Health Services*. Rental of breast pumps is always excluded.
7. supplies, equipment and similar incidentals for personal comfort. Examples include, but are not limited to:
 - air conditioners;
 - air purifiers and filters;
 - batteries and battery chargers, except as described under *Hearing Aids* and under *Durable Medical Equipment* in Section 6, *Details for Covered Health Services*;
 - dehumidifiers and humidifiers;
 - ergonomically correct chairs;
 - non-Hospital beds, comfort beds, motorized beds and mattresses;
 - car seats;
 - chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
 - exercise equipment and treadmills;
 - hot tubs, Jacuzzis, saunas and whirlpools;

- medical alert systems;
- music devices;
- personal computers;
- pillows;
- power-operated vehicles;
- radios;
- strollers;
- safety equipment;
- vehicle modifications such as van lifts;
- video players;
- home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides); and
- personal hygiene protection (for example, adult diapers).

Physical Appearance

1. Cosmetic Procedures, as defined in Section 13, *Glossary*, are excluded from coverage. Examples include, but are not limited to:
 - scar removal or revision procedures;
 - breast enhancement procedures; and
 - removal or replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.
2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, spa treatments, and diversion or general motivational programs.
3. weight loss programs whether or not they are under medical supervision or determined to be Medically Necessary, even if for morbid obesity.
4. wigs regardless of the reason for the hair loss.
5. treatment of benign gynecomastia.

Procedures and Treatments

1. biofeedback.
2. tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
3. hair removal or treatments for hair loss by any means.
4. procedures and treatments for skin wrinkles or any procedure or treatment to improve the appearance of the skin, including, but not limited to, face lifts.
5. treatment for spider veins.
6. skin abrasion procedures performed as a treatment for acne.
7. medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer).

8. rehabilitation services and Chiropractic Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including, but not limited to, routine, long-term or maintenance/preventive treatment.
9. speech therapy, except as described under *Developmental Delay Services* or under *Rehabilitation Services – Outpatient Therapy* in Section 6, *Details for Covered Health Services*.
10. a procedure or surgery to remove fatty tissue and/or hanging skin on any part of the body including, but not limited to, panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy, even if hanging skin is due to weight loss or to bariatric surgery otherwise covered under the Plan.
11. psychosurgery (lobotomy).
12. stand-alone multi-disciplinary smoking cessation programs. These programs usually include services by health care Providers specializing in smoking cessation, such as a psychologist or social worker, and also usually include intensive psychological support, behavior modification techniques and medications to control cravings.
13. chelation therapy, except to treat heavy metal poisoning.
14. services provided by a chiropractor to treat a condition unrelated to an identifiable neuromusculoskeletal condition, such as asthma or allergies, or services that do not meet the definition of Chiropractic Treatment shown in Section 13, *Glossary*.
15. therapy treatments or procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
16. gender reassignment surgery and related services.
17. non-surgical bariatric treatment, even if for morbid obesity.
18. bariatric surgery for Employees except as described under *Bariatric Surgery* in Section 6, *Details for Covered Health Services* or bariatric surgery for Dependents or Retirees.
19. oral appliances and devices used to treat TMJ pain disorders or dysfunction of the joint, jaw, jaw muscles and nerves.
20. the following services for the diagnosis and treatment of TMJ: any non-surgical treatment, including, but not limited to, clinical examinations, arthrocentesis and trigger-point injections; surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment and dental restorations.
21. health care services performed at a diagnostic Facility (Hospital or Alternate Facility) without a written order from a Provider.
22. health care services which are self-directed to a free-standing or Hospital-based diagnostic Facility.
23. health care services performed at a diagnostic Facility (Hospital or Alternate Facility), when ordered by a Provider affiliated with the diagnostic Facility and when that Provider is not

actively involved in your medical care either prior to ordering the service or after the service is received.

This exclusion does not apply to mammography testing or bone density screening.

24. breast reduction surgery that is determined to be a Cosmetic Procedure.

This exclusion does not apply to breast reduction surgery that the Plan determines is for the treatment of a physiologic functional impairment or is coverage required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 6, *Details for Covered Health Services*.

Providers

1. health care services performed by a Provider who is your family member by birth or marriage, including, but not limited to, your spouse, brother, sister, parent or child.
2. health care services that a Provider performs on himself or herself.
3. health care services performed by a Provider who has your same legal residence.
4. health care services performed by an unlicensed Provider or a Provider who is providing health care services outside of the scope of his/her license.
5. any annual fee, retainer or similar fee paid to a Provider.

Reproduction/Infertility

1. health services and associated expenses for infertility treatments, including, but not limited to, artificial insemination, intra-fallopian transfer or other assisted reproductive technology, regardless of the reason for the treatment. Also excluded are any services or supplies used in any procedure in preparation for or performed as a direct result of and immediately after any of the excluded procedures.

This exclusion does not apply to services required to treat or correct underlying causes of infertility.

Note: If a Pregnancy results from excluded infertility treatment, Pregnancy and newborn services will be covered as described under *Pregnancy - Maternity Services* in Section 5, *Schedule of Benefits and Coverage* and Section 6, *Details for Covered Health Services*.

2. storage and retrieval of all reproductive materials (examples include, but are not limited to, eggs, sperm, testicular tissue and ovarian tissue).
3. in vitro fertilization regardless of the reason for treatment. Also excluded are any services or supplies used in any procedure in preparation for or performed as a direct result of and immediately after in vitro fertilization.
4. surrogate parenting, donor eggs, donor sperm and host uterus.
5. the reversal of voluntary sterilization.
6. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes.
7. selective reduction surgery for multiple gestations.

This exclusion does not apply if a Physician states the Participant's life would be endangered if the fetus was carried to term.

8. elective surgical, non-surgical or drug induced Pregnancy termination.

This exclusion does not apply if the Pregnancy termination is Medically Necessary or if the Pregnancy is caused by a criminal act.

9. services provided by a labor aide (doula).
10. parenting, pre-natal or birthing classes.

This exclusion does not apply to breastfeeding counseling as mandated by the Affordable Care Act.

Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 9, *Coordination of Benefits (COB)*.
2. under workers' compensation, no-fault automobile coverage or similar plan if you could purchase or elect it, or could have it purchased or elected for you.
3. while on active military duty.
4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and Facilities are reasonably accessible, as determined by the Plan.

Transplants

1. health services for organ and tissue transplants, except as identified under *Transplant Services* in Section 6, *Details for Covered Health Services*, unless the Plan determines the transplant to be appropriate according to the Plan's transplant guidelines.
2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (for example, a device that supports the heart while the patient waits for a suitable donor heart to become available).

Travel

1. travel or transportation expenses, even if ordered by a Physician. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 6, *Details for Covered Health Services*.

Types of Care

1. Custodial Care as defined in Section 13, *Glossary*, or maintenance care.
2. Domiciliary Care, as defined in Section 13, *Glossary*.
3. multi-disciplinary pain management programs provided on an Inpatient basis for acute pain or for exacerbation of chronic pain, unless determined by the Plan to be Medically Necessary.
4. Private Duty Nursing received on an Inpatient basis.

5. with respect to home health care, Hospice care, Outpatient Private Duty Nursing services or care received in a Skilled Nursing Facility or Inpatient Rehabilitation Facility, the following:
 - services provided for the convenience of the Participant or Participant's family, such as assistance with bathing, feeding, mobilizing, exercising or homemaking;
 - services as a "sitter" or companion; and
 - general supervision of exercises taught to the Participant including, but not limited to, the actual carrying out of a maintenance program.
6. with respect to home health care, Hospice care or Outpatient Private Duty Nursing services, the following:
 - administration of oral medication;
 - periodic turning and positioning in bed;
 - food or home-delivered meals;
 - social casework or homemaker services; and
 - transportation services.
7. respite care (Skilled Care or unskilled care to provide relief for a permanent caregiver), unless provided as part of an integrated Hospice care program of services provided by a licensed Hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 6, *Details for Covered Health Services*.
8. rest cures.
9. services of personal care attendants.
10. work hardening programs (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. implantable lenses used only to correct a refractive error.
2. contact lens exams; purchase cost and associated fitting charges for eyeglasses or contact lenses. This exclusion does not apply to contact lenses when prescribed to treat a Sickness or Injury of the cornea.
3. dispensing fees for hearing aids.
4. repairs to a hearing aid, even if the hearing aid purchase was a Covered Health Service under the Plan.
5. bone anchored hearing aids except when either of the following applies:
 - for Participants with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
 - for Participants with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid, as documented by a Physician.

The Plan will not pay for more than one bone anchored hearing aid per Participant who meets the above coverage criteria during the entire period of time the Participant is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Participants who meet the above coverage are not covered, other than for malfunctions.

6. eye exercise or vision therapy, except any of the following therapies when ordered by a Physician to treat the specific related condition:
 - occlusion therapy for amblyopia;
 - prism adaptation therapy for esotropia; or,
 - orthoptic or vision therapy for convergence insufficiency.
7. surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. autopsies and other coroner services and transportation services for a corpse.
2. charges for:
 - missed appointments;
 - room or Facility reservations;
 - completion of claim forms; and
 - record processing.
3. charges prohibited by federal anti-kickback or self-referral statutes.
4. diagnostic tests that are:
 - delivered in other than a Physician's office or health care Facility; or
 - self-administered home diagnostic tests, including but not limited to, HIV and Pregnancy tests.
5. expenses for health services and supplies:
 - that would otherwise be considered Covered Health Services and are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Participants who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;
 - that are received after the date your coverage under this Plan ends, including health services for medical conditions that began before the date your coverage under the Plan ends;
 - 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 this Plan;
 - that exceed Eligible Expenses or any specified limitation in this MBPD; or
 - for which a Non-Network Provider waives the Copay, Annual Deductible or Coinsurance amounts.
6. foreign language and sign language services.
7. long term (more than 30 days) storage of blood, umbilical cord or other biological material. Examples include, but are not limited to, cryopreservation of tissue, blood and blood products.
8. health services and supplies that do not meet the definition of a Covered Health Service as shown in Section 13, *Glossary*.

9. health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service even if the treatment of the complication is considered to be Medically Necessary, prescribed by a Physician or if the Participant has medical or psychological conditions that could be helped by the surgery, services, supplies, treatments, or procedures.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

10. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:
- required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration;
 - conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Details for Covered Health Services*;
 - related to judicial or administrative proceedings or orders; or
 - required to obtain or maintain a license of any type.

SECTION 8 - CLAIMS PROCEDURES

What this section includes:

- How Network and Non-Network claims work; and
- What you may do if your claim is denied, in whole or in part.

Note: You may designate an Authorized Representative who has the authority to represent you in all matters concerning your claim or appeal of a claim determination. If you have an Authorized Representative, any references to “you” or “Participant” in this Section 8 will refer to the Authorized Representative. See *Authorized Representative* below for details.

Out-of-Area Claims Processing for Network and Non-Network Services

UnitedHealthcare has a nationwide Network of participating Providers. Claims processing for Benefits depends on whether you receive Covered Health Services from a Network or a Non-Network Provider.

Network Services

In general, if you receive Covered Health Services from a Network Provider, UnitedHealthcare will pay the Physician or Facility directly. If a Network Provider bills you for any Covered Health Service other than your Copay or Coinsurance, please contact the Provider or call UnitedHealthcare at (866) 336-9371 toll free for assistance.

Keep in mind, you are responsible for paying any Copay or Coinsurance owed to a Network Provider at the time of service, or when you receive a bill from the Provider.

Non-Network Services

If you receive a bill for Covered Health Services from a Non-Network Provider, you (or the Provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the following address:

UnitedHealthcare – Claims
P.O. Box 740809
Atlanta, GA 30374-0809

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting www.myuhc.com/hs, calling UnitedHealthcare at (866) 336-9371 toll free or contacting your Benefits Coordinator. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
- the Participant’s name, age and relationship to the Subscriber;
- the ID number as shown on your HealthSelect medical ID card;
- the name, address and tax identification number of the Provider of the service(s);
- a diagnosis from the Physician;
- the date of service;

- an itemized bill from the Provider that includes:
 - the Current Procedural Terminology (CPT) codes;
 - a description of, and the charge for, each service;
 - the date the Sickness or Injury began; and
 - a statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other insurer(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

Intentionally false statements of material fact may result in adverse action against you, including, but not limited to, termination of your health coverage and expulsion from the GBP.

The above information should be filed with UnitedHealthcare at the following address:

UnitedHealthcare – Claims
P.O. Box 740809
Atlanta, GA 30374-0809

Claim Payment and Assignment

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. If you have used a Non-Network Provider, it is your responsibility to pay the Non-Network Provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

UnitedHealthcare will pay Benefits to you unless:

- the Provider notifies UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that Provider; or
- you make a written request for the Non-Network Provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, to your Provider, and not to a third party, even if your Provider has assigned Benefits to that party.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, an online Health Statement will be available for your review at www.myuhc.com/hs. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

You may request that UnitedHealthcare send you a paper copy of a Health Statement by calling (866) 336-9371 toll free. See Section 13, *Glossary*, for the definition of Health Statement.

Explanation of Benefits (EOB)

UnitedHealthcare will send you a paper copy of an Explanation of Benefits (EOB) after processing each of your medical claims submitted. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like to stop receiving paper copies of the EOBs and only receive EOBs electronically, you may “go green” and turn off paper

copies online at www.myuhc.com/hs. See Section 13, *Glossary*, for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims

All claim forms for Non-Network services must be submitted within 18 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 18-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at (866) 336-9371 toll free before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied Pre-Service Request for Benefits, concurrent claim, or Post-Service Claim, or appeal a rescission of coverage you or your Authorized Representative must submit your appeal as described below in writing within 180 days of receiving the adverse benefit determination. This communication should include:

- the Participant's name and ID number as shown on the HealthSelect medical ID card;
- the Provider's name;
- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your appeal.

You or your Authorized Representative may send a written appeal to:

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432

You do not need to submit appeals of Urgent Care Requests for Benefits in writing. For Urgent Care Requests for Benefits that have been denied, you or your Provider should call UnitedHealthcare at (866) 336-9371 toll free to request an appeal.

Types of claims

The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent Care Request for Benefits;
- Pre-Service Request for Benefits;
- concurrent care claim;
- Post-Service Claim; or
- rescission of coverage.

First Internal Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial Benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you and your Provider will receive a written explanation of the reasons and facts relating to the denial and a description of the additional appeal procedures. If UnitedHealthcare overturns the denial, you and your Provider will receive notification of its decision and Benefits will be paid, as appropriate.

Notes:

- A denial of Benefits for medical services does not mean that you cannot receive the medical services. A denial of the Benefits simply means that the medical services are not covered under the Plan and no payments will be made to you or any Providers by the Plan if you receive the denied medical services, unless you win a subsequent appeal.
- If your Urgent Care Request for Benefits was denied, you may request an expedited external review at the same time that you request an expedited internal appeal to UnitedHealthcare. UnitedHealthcare will review the request to determine if the appeal should go directly to the expedited external review instead of through the internal appeal process. If the request for appeal does not meet the expedited external appeal criteria as determined by UnitedHealthcare, the appeal will be handled as an expedited internal appeal to UnitedHealthcare.

Second Internal Appeal to UnitedHealthcare (of an Urgent Care Request for Benefits, a Pre-Service Request for Benefits, or a Concurrent Claim)

If you are not satisfied with the first internal appeal decision regarding an Urgent Care Request for Benefits, a Pre-Service Request for Benefits, or a concurrent claim, you have the right to request a second internal appeal from UnitedHealthcare. You must file a written request for the second internal appeal within 60 days from your receipt of the first internal appeal determination notification.

If your non-urgent Pre-Service Request for Benefits is denied, you may file a second internal appeal to UnitedHealthcare. If the denial is upheld at the second internal appeal level, UnitedHealthcare will notify you of the reasons for its decision and that your internal appeal options are exhausted. If the appeal involves issues of medical judgment, you may request an external review. If UnitedHealthcare overturns its decision at the second internal appeal level, UnitedHealthcare will notify you of its decision and Benefits will be paid, as appropriate.

Note: Upon written request and free of charge, Participants may examine documents relevant to their claims and/or appeals and submit opinions and comments. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor.

Second Internal Appeal to ERS (of a Post-Service Claim or a Rescission of Coverage)

If you are not satisfied with the first internal appeal decision regarding a Post-Service Claim or a rescission of coverage, you have the right to request a second internal appeal from ERS. You must file a written request for the second internal appeal within 90 days from your receipt of the first level appeal determination notification.

If ERS upholds the denial at the second internal appeal level, ERS will notify you of the reasons for its decision and that your internal appeal options are exhausted. If your appeal involves issues of medical judgment or a rescission of coverage, you may request an external review. If ERS overturns the denial, UnitedHealthcare will notify you and Benefits will be paid, as appropriate.

ERS does not review denials of Pre-Service Requests for Benefits, Urgent Care Requests for Benefits or concurrent claims.

UnitedHealthcare and ERS will complete reviews within generally applicable time periods, unless additional information is needed.

Mediation Rights

You may have mediation rights under Chapter 1467 of the Texas Insurance Code if your out-of-pocket obligation to a Non-Network Hospital-based Physician (radiologist, anesthesiologist, pathologist, emergency department Physician, neonatologist or assistant surgeon) is greater than \$500 after your payment of any Copayments, Deductibles and Coinsurance relating to your claim and if the medical services were provided in a Network Hospital. You may assert your mediation rights by filing a mediation request with the Texas Department of Insurance (TDI). Please submit a Health Insurance Mediation Request Form directly to TDI and not to ERS.

Tables 5 through 7 below describe the time frames which you and UnitedHealthcare are required to follow.

TABLE 5	
Urgent Care Request for Benefits¹	
Action to Be Taken	Timing²
If your Request for Benefits is incomplete, UnitedHealthcare must notify you within:	24 hours
You must then provide the completed Request for Benefits to UnitedHealthcare within	48 hours after receiving notice of additional information required
UnitedHealthcare must notify you and your Provider of the benefit determination within:	72 hours
If UnitedHealthcare denies your Request for Benefits, you must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first internal appeal decision within:	72 hours after receiving the appeal

¹You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care Request for Benefits.

²From when the request is made unless otherwise noted below.

TABLE 6	
Pre-Service Request for Benefits	
Action to Be Taken	Timing¹
If your Request for Benefits is filed improperly with UnitedHealthcare, it must notify you within:	5 days
If your Request for Benefits is incomplete UnitedHealthcare must notify you within:	15 days
You must then provide completed Request for Benefits information to UnitedHealthcare within:	45 days
UnitedHealthcare must notify you of the benefit determination:	
■ if your Request for Benefits is complete, within:	15 days
■ after receiving the completed Request for Benefits (if your Request for Benefits was incomplete as filed), within:	15 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first internal appeal decision within:	15 days after receiving the first internal appeal
You must appeal the denial of your first internal appeal (by filing a second internal appeal) no later than	60 days after receiving the first internal appeal decision
UnitedHealthcare must notify you of the second internal appeal decision within:	15 days after receiving the second internal appeal

¹From when the request is made unless otherwise noted below.

TABLE 7	
Post-Service Claims	
Action to Be Taken	Timing¹
If your claim is incomplete, UnitedHealthcare must notify you within:	30 days
You must then provide completed claim information to UnitedHealthcare within:	45 days
UnitedHealthcare must notify you of the benefit determination:	
■ if the claim was complete as filed, within:	30 days
■ after receiving the completed claim (if the claim was incomplete as filed), within:	30 days

TABLE 7	
Post-Service Claims	
Action to Be Taken	Timing¹
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first internal appeal decision no later than:	30 days after receiving the first internal appeal
You must appeal the denial of your first internal appeal (by filing a second internal appeal with ERS) no later than:	90 days after receiving the first internal appeal decision
UnitedHealthcare or ERS must notify you of the second internal appeal decision within:	30 days after receiving the second internal appeal

¹From when the request is made unless otherwise noted below.

External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare or ERS, or if UnitedHealthcare or ERS fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an immediate external review of the determination made by UnitedHealthcare or ERS. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of an adverse benefit determination based upon any of the following:

- clinical reasons (the determination involves a question of medical judgment);
- rescission of coverage (coverage that was terminated retroactively); or
- as otherwise required by applicable law.

Note: You may also have the right to pursue external review in the event that UnitedHealthcare or ERS failed to comply with the internal claims and appeals process, except for those failures that are based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to you.

You or your Authorized Representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your Authorized Representative may request an expedited external review, in urgent situations as detailed below, by calling UnitedHealthcare at (866) 336-9371 toll free or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you receive UnitedHealthcare's or ERS' determination.

An external review request should include all of the following:

- a specific request for an external review;
- the Participant's name, address, and insurance ID number;

- your Authorized Representative's name and address, when applicable;
- the service that was denied, the date of service, the Provider's name; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- a preliminary review by UnitedHealthcare of the request;
- a referral of the request by UnitedHealthcare to the IRO;
- the review by the IRO; and
- a decision by the IRO.

Within the applicable time frame after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the Participant for whom the request was submitted meets all of the following:

- was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue you a notification in writing within five business days of receiving the request for the external review. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

UnitedHealthcare will provide the assigned IRO with the documents and information considered in making UnitedHealthcare's or ERS' determination. The documents include:

- all relevant medical records;
- all other documents relied upon by UnitedHealthcare or ERS;
- all other information or evidence that you or your Provider submitted regarding the claim; and
- all other information or evidence that you or your Provider wish to submit regarding the claim, including, as explained below, any information or evidence you or your Provider wish to submit that was not previously provided.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date you receive notice from the IRO, any additional information that you want the IRO to consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days. In reaching a decision, the IRO will review the claim anew and will not be bound by any decisions or conclusions reached by UnitedHealthcare or ERS. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless the IRO requests additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare's or ERS' determination, UnitedHealthcare will notify you within 48 hours of receiving the IRO's decision. The Plan will immediately provide coverage or payment of the Benefits at issue in accordance with the terms and conditions of the Plan. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure and you will have exhausted your appeal rights.

All Final External Review Decisions by an IRO are final and binding on all parties and not subject to further appeal rights.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the Participant or would jeopardize the Participant's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- a final appeal decision, if the determination involves a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the Participant or would jeopardize the Participant's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the Participant received Emergency services, but has not been discharged from a Facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the Participant meets both of the following:

- was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided; and
- has provided all the information and forms required so that UnitedHealthcare may process the request.

After completing the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare

will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the Final External Review Decision for an expedited external review as expeditiously as the Participant’s medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the IRO’s notice of the Final External Review Decision is not in writing, within 48 hours of providing such notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

All Final External Review Decisions by an IRO are final and binding on all parties and not subject to further appeal rights.

You may contact UnitedHealthcare at (866) 336-9371 toll free for more information regarding external review rights, or if making a verbal request for an expedited external review.

Table 8 below describes the time frames which you, UnitedHealthcare and the IRO are required to follow.

TABLE 8	
External Review	
Action to Be Taken	Timing¹
You must submit a request for external review to UnitedHealthcare within:	Four months after the date you receive the second internal appeal determination
For an expedited external review, the IRO will provide notice of its determination within:	72 hours
For a standard external review, UnitedHealthcare will complete a preliminary review to ensure the request meets requirements for an external review within:	5 business days
You may submit in writing to the IRO any additional information that you want the IRO to consider within	10 business days
For a standard external review, the IRO will provide written notice of its determination within:	45 days² after receiving the request for the external review

¹From when the request is made unless otherwise noted below.

²This time frame may be extended if the IRO requests additional time and you agree.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Request for Benefits as defined above, your request will be decided within 24 hours, provided your request is

made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

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

Authorized Representative

A Participant may have one Authorized Representative, and only one Authorized Representative at a time, to assist in submitting a claim or appealing a claim.

An Authorized Representative shall have the authority to represent the Participant in all matters concerning the Participant's claim or appeal of a claim determination. If the Participant has an Authorized Representative, any references to "you" or "Participant" in this Section 8 will refer to the Authorized Representative.

One of the following persons may act as a Participant's Authorized Representative:

- an individual designated by the Participant in writing on a form approved by UnitedHealthcare;
- a health care Provider if the claim is an Urgent Care claim, or if the Participant has designated the Provider in writing in a form approved by UnitedHealthcare. However, a health care Provider may not be an Authorized Representative for the appeal of a claim;
- a person holding the Participant's durable power of attorney;
- if the Participant is legally incapacitated, a person appointed as guardian to have care and custody of the Participant by a court of competent jurisdiction; or
- if the Participant is a minor, the Participant's parent or legal guardian, unless UnitedHealthcare is notified that the Participant's claim involves health care services where the consent of the Participant's parent or legal guardian is or was not required by law then the Participant shall represent himself or herself with respect to the claim.

The authority of an Authorized Representative shall continue for the period specified in the Participant's appointment of the Authorized Representative or until the Participant is legally competent to represent himself or herself and notifies UnitedHealthcare in writing that the Authorized Representative is no longer required.

Communication with Authorized Representative –

1. If the Authorized Representative represents the Participant because the Authorized Representative is the Participant's parent or legal guardian or attorney in fact under a durable power of attorney, UnitedHealthcare shall send all correspondence, notices and benefit determinations in connection with the Participant's Claim to the Authorized Representative.
2. If the Authorized Representative represents the Participant in connection with the submission of a Pre-Service Claim, including a claim involving Urgent Care, UnitedHealthcare shall send all correspondence, notices and benefit determinations in connection with the Participant's claim to the Authorized Representative.

3. If the Authorized Representative represents the Participant in connection with the submission of a Post-Service Claim, UnitedHealthcare will send all correspondence, notices and benefit determinations in connection with the Participant's Claim to the Participant, but UnitedHealthcare will provide copies of such correspondence to the Authorized Representative upon request.
4. It will take UnitedHealthcare at least 30 days to notify all of its personnel about the termination of the Participant's Authorized Representative. It is possible that UnitedHealthcare may communicate information about the Participant to the Authorized Representative during this 30-day period.

SECTION 9 - COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans;
- How coverage is affected if you become eligible for Medicare; and
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including, but not limited to, any one of the following:

- another employer-sponsored health benefits plan;
- another group insurance plan;
- a medical component of a group long-term care plan, such as skilled nursing care;
- no-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an automobile insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

COB does not apply if your other health plan is a health insurance policy that is individually underwritten or issued.

If coverage is provided under two or more plans, COB determines which plan is Primary and which plan is Secondary. The plan considered Primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining Eligible Expenses may be paid under the other plan, which is considered Secondary. The Secondary Plan may determine its benefits based on the benefits paid by the Primary Plan.

Don't forget to update your Dependents' Medical Coverage Information

Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to www.myuhc.com/hs or call (866) 336-9371 toll-free to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- a plan that covers a Participant as an employee pays benefits before a plan that covers the Participant as a dependent;
- the plan that has covered the individual claimant for the longest period will pay first; the expenses must be covered in part under at least one of the plans;
- the plan that covers an active employee pays before a plan covering a laid-off or retired employee;
- your Dependent children will receive Primary coverage from the parent whose birth date occurs first in a Calendar Year. If both parents have the same birth date, the plan that that has been in effect the longest is the Primary Plan. This birthday rule applies only if:

- the parents are married or living together whether or not they have ever been married and not legally separated; or
- a court decree awards joint custody to the parents without specifying that one parent has the responsibility to provide health care coverage;
- if two or more plans cover a Dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
 - the parent with custody of the child; then
 - the spouse of the parent with custody of the child; then
 - the parent not having custody of the child; then
 - the spouse of the parent not having custody of the child;
- if you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will be the Primary Plan;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan is the Primary Plan; and
- finally, if none of the above rules determines which plan is Primary or Secondary, the allowable expenses (as defined below in the textbox titled *What is an allowable expense?*) shall be shared equally between the plans meeting the definition of Plan.

Under any of the circumstances above, this Plan will not pay more than it would have paid had it been the only plan in effect.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan – Examples

1) Let's say you and your spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as a Subscriber under this Plan, and as a Dependent under your spouse's plan, this Plan will pay Benefits for the Physician's office visit first.

2) Again, let's say you and your spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your spouse's birthday to determine which plan pays first. If you were born on June 11 and your spouse was born on May 30, your spouse's plan will pay first.

Table 9 summarizes common situations of dual coverage and whether HealthSelect would be considered the Primary Plan or the Secondary Plan.

TABLE 9		
Subscriber is...	...and is covered as a dependent under another plan by:	...then HealthSelect is:
an Active Employee	spouse's employer plan	the Primary Plan
an Active Employee	spouse's retiree plan	the Primary Plan
a Retiree	spouse's employer plan	the Primary Plan
a Retiree	spouse's retiree plan	the Primary Plan

TABLE 9		
Subscriber is...	...and has other coverage through:	...then HealthSelect is:
an Active Employee	the Subscriber's second active employment	either Primary or Secondary depending on which plan is in force the longest
an Active Employee	the Subscriber's retirement from another employer	the Primary Plan
a Retiree	the Subscriber's second active employment	the Secondary Plan
a Retiree	the Subscriber's retirement from another employer	either Primary or Secondary depending on which plan is in force the longest
Dependent is...	...and is covered by a Subscriber who is:	...then HealthSelect is:
an active employee of a non-GBP Employer	an Active Employee	the Secondary Plan
an active employee of a non-GBP Employer	a Retiree	the Secondary Plan
a retiree of a non-GBP Employer	an Active Employee	the Primary Plan
a retiree of a non-GBP Employer	a Retiree	the Secondary Plan

When This Plan is Secondary

When this Plan is the Secondary Plan, the Plan determines the amount it will pay for a Covered Health Service according to the following:

- the Plan determines the amount it would have paid based on the allowable expense.
- the Plan pays the difference between the amount paid by the Primary Plan and this Plan's allowable expense.
- the Plan does not pay more than the amount the Plan would have paid had it been the only plan providing coverage.
- the maximum combined payments from all plans cannot exceed 100% of the total allowable expense.

Note: See the textbox below for the definition of allowable expense.

You may be responsible for any Copay, Coinsurance or Annual Deductible payments as part of the COB payment.

Determining the Allowable Expense When This Plan is Secondary

If this Plan is Secondary and the health care services meet the definition of a Covered Health Service under this Plan, the allowable expense is the Primary Plan's network rate for those services. If the Primary Plan bases its reimbursement on reasonable and customary charges, the

allowable expense is the Primary Plan's reasonable and customary charge. If both the Primary Plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

When the Provider is a Network Provider for both the Primary Plan and this Plan, the allowable expense is the Primary Plan's network rate. When the Provider is a network Provider for the Primary Plan and a Non-Network Provider for this Plan, the allowable expense is the Primary Plan's network rate. When the Provider is a Non-Network Provider for the Primary Plan and a Network Provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the Primary Plan. When the Provider is a Non-Network Provider for both the Primary Plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges.

What is an allowable expense?

For purposes of COB, an allowable expense is a health care expense that meets the definition of a Covered Health Service under this Plan.

When a Participant Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay Benefits as the Secondary Plan to Medicare when you become eligible for Medicare, even if you don't elect to have Medicare. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays Benefits second:

- persons who are Actively at Work with a State Agency or with an Institution of Higher Education and their spouses; and
- individuals with End-Stage Renal Disease for a limited period of time, as determined by Medicare.

If you are Actively at Work and not Medicare-eligible but your spouse is Medicare-eligible (for reasons other than End-Stage Renal Disease), this Plan will be Primary for your spouse if he or she is your Dependent.

If you are Actively at Work and are Medicare-eligible due to End-Stage Renal Disease, Medicare will be Primary and this Plan will be Secondary.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is Secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the Provider accepts Medicare. If the Provider does not accept Medicare, the Medicare limiting charge (the most a Provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

If you retired and turned age 65 on or before September 1, 1992, Medicare is the Primary Plan and the Plan is Secondary Plan for Part A Benefits. However, if you do not have Medicare Part B, this Plan is the Primary Plan for Part B Benefits, making Medicare the Secondary Plan for Part B Benefits. This also applies to your covered spouse if he or she turned age 65 on or before September 1, 1992.

If you retired after September 1, 1992 and you are eligible for Medicare, this Plan is the Secondary Plan to Medicare Part A and Part B Benefits, whether or not you are enrolled in Medicare. Benefits payable under this Plan will be reduced by the amount that Medicare would have paid just as if you had been enrolled in Medicare.

If you are not eligible for Medicare Part A because you or your spouse did not contribute to Social Security, this Plan will be the Primary Plan for Medicare Part A Benefits if no other medical coverage is available to you or your covered spouse. However, unless you retired and turned age 65 on or before September 1, 1992, this Plan is the Secondary Plan to Medicare Part B Benefits.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount it should have paid.

If the Plan pays you more than it should under this COB section, you should pay the excess back promptly. Otherwise, ERS may recover the overpayment by offsetting the amount owed by ERS from future Benefits or by taking other legal action.

If the Plan overpays a health care Provider, the Plan may recover the excess amount from the Provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays Benefits to or for a Participant, that Participant, or any other person or organization that was paid, must make a refund to the Plan if:

- the Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Participant, but all or some of the expenses were not paid by the Participant or were not legally required to be paid by the Participant;
- all or some of the payment the Plan made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that the Plan should have paid under the Plan. If the refund is due from another person or organization, the Participant agrees to help the Plan get the refund if requested.

If the Participant, or any other person or organization that was paid, does not promptly refund the full amount, ERS may reduce the amount of any future Benefits for the Participant that are payable under the Plan. The reductions will equal the amount of the required refund. Alternatively, ERS may impose one or more sanctions against the involved Participant(s) under Section 1551.351, Texas Insurance Code.

SECTION 10 - SUBROGATION AND REIMBURSEMENT

What this section includes:

- How your Benefits are impacted if you suffer a Sickness or Injury caused by a third party.

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

Right of Recovery

The Plan has the right to recover Benefits it has paid on the Participant's behalf that were:

- made in error;
- due to a mistake in fact;
- incorrectly paid by the Plan during the time period of meeting the Deductible for the Calendar Year; or
- incorrectly paid by the Plan during the time period of meeting any Out-of-Pocket Maximum for the Calendar Year.

Benefits paid because the Participant misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for the Participant that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan incorrectly pays Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting any Out-of-Pocket Maximum for the Calendar Year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits by:

- submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

Right to Subrogation

The right to subrogation means the Plan is substituted to and shall succeed to any and all legal claims that the Participant may be entitled to pursue against any third party for Benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is or may be considered responsible. Subrogation applies when the Plan has paid to or on behalf of the Participant Benefits for a Sickness or Injury for which a third party is or may be considered responsible, e.g. a third party's insurance carrier if the Participant is involved in an auto accident with a third party.

To the maximum extent allowed by Texas law, the Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for any

Benefits the Plan has paid to or on behalf of the Participant relating to any Sickness or Injury for which any third party is or may be responsible.

Right to Reimbursement

The right to reimbursement means that if a third party is or may be responsible to pay for the Participant's Sickness or Injury for which the Participant receives a settlement, judgment, or other recovery from any third party, the Participant must use those proceeds to return to the Plan, to the maximum extent allowed by Texas law, Benefits the Participant received for that Sickness or Injury.

Third Parties

The following persons and entities are considered third parties:

- a person or entity alleged to have caused the Participant to suffer a Sickness, Injury or medical damages, or who is legally responsible to pay for the Sickness, Injury or medical damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or medical damages; or
- any other persons or entities who are responsible for paying losses caused by the Participant's Sickness or Injury when such payments are subject to subrogation under Texas law.

Subrogation and Reimbursement Provisions

As a Participant, you agree to the following:

- up to the maximum amount allowed by Texas law, the Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, to the extent allowed by law, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical Providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds you recover from an allegedly responsible third party.
- the Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized and whether or not the third party disclaims liability. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, and no amount of associated costs, including, but not limited to, attorneys' fees and out-of-pocket expenses shall be deducted from the Plan's recovery without the Plan's express written consent, except as required by Texas law. No so-called equitable or common law, "Made-Whole Doctrine," "Fund Doctrine," or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat or limit this right.
- regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) arbitration, judgment or other monetary award, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule shall limit the Plan's subrogation and reimbursement rights that are allowed under Texas law.

- you will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:
 - complying with the terms of this section;
 - providing any relevant information requested;
 - signing and/or delivering such documents as the Plan or its administering firm reasonably request to secure the subrogation and reimbursement claim;
 - notifying the Plan, in writing, of any potential legal claim(s) you may have against any and all third parties for acts which caused Benefits to be paid or become payable;
 - responding promptly to requests for information about any accident or injuries;
 - appearing at medical examinations and legal proceedings, such as depositions or hearings; and
 - obtaining the Plan's consent or its administering firm's consent before releasing any party from liability or payment of medical expenses.
- if you receive payment as part of a settlement or judgment from any third party as a result of a Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to it under Texas law, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- if the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you to the maximum extent allowed by Texas law.
- you may not accept any settlement that does not fully reimburse the Plan to the maximum extent allowed by Texas law, without its written approval.
- upon the Plan's request, you will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has paid for a Sickness or Injury allegedly caused by a third party or for which a third party is legally responsible to pay for your Sickness or Injury.
- the Plan's rights to recovery will not be reduced due to your own comparative negligence.
- the Plan may, at its option, take necessary and appropriate action to assert its rights under this section, including, but not limited to, filing suit in your name, which does not obligate it in any way to pay you part of any recovery the Plan might obtain.
- the provisions of this section also apply to the Participant's spouse, parents, guardian, or other representative of a Dependent child or Dependent spouse who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- the Participant's spouse and the Dependent's spouse are jointly and severally liable for the Plan's subrogation and reimbursement rights herein;
- in case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- your failure to cooperate with the Plan or its agents is considered a violation of the Plan. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.

- if a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Participant.
- the Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- subject to ERS' oversight and control, the Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.
- no allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100 percent of its interest allowed under Texas law unless the Plan provides written consent to the allocation.

As used in this Section 10, "Texas law" means Texas Civil Practices and Remedies Code, Chapter 140.

Note: The subrogation rights and obligations under the Plan shall be governed by Texas law regardless of where the Participant resides or whether the injury occurs in or outside the state of Texas.

Example

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. If you subsequently bring suit against the insurer of the person who caused the accident and receive a settlement, or receive payment from the insurer without bringing suit, the Plan is entitled to direct payment from you for the Benefits it paid.

SECTION 11 - WHEN COVERAGE ENDS

What this section includes:

- Circumstances that cause coverage to end;
- Extended coverage; and
- How to continue coverage after it ends.

Your eligibility for Benefits automatically ends on the date that your coverage ends. When your coverage ends, the Plan will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after your coverage ended, even if the underlying medical condition occurred before your coverage ended, you are hospitalized, or are otherwise receiving medical treatment.

Your coverage under the Plan will end on the earliest of:

- the last day of the month your employment with your Employer ends;
- the last day of the month your contributions were paid in full if you stop making the required contributions;
- the last day of the month you are no longer eligible for coverage;
- the last day of the month that UnitedHealthcare receives written notice from ERS to end your coverage, or the date specified in the notice;
- the last day of the month you retire, unless you are eligible for other coverage as a Retiree; or
- the effective date you are expelled from the Plan as provided under Chapter 1551, Texas Insurance Code.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the last day of the month your contributions were paid in full if you stop making the required contributions;
- the last day of the month that UnitedHealthcare receives written notice from ERS to end your coverage, or the date specified in the notice;
- the last day of the month your Dependents become ineligible as Dependents under this Plan; or
- the effective date you are expelled from the Plan as provided under Chapter 1551, Texas Insurance Code.

Extended Coverage

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches 26 years of age, the Plan will continue to cover the child, as long as the child is mentally or physically incapacitated to such an extent that he or she is dependent upon you for care or support.

You must apply with ERS to continue benefits before the first day of the month following the child's 26th birthday. If an extension of coverage is temporarily approved, you must reapply with ERS for an additional extension of coverage for the child before the prior temporary extension approval's expiration date.

If you have a disabled Dependent who was not covered at the time they turned age 26, or if your Dependent becomes disabled after they turned age 26, you may apply for coverage for them during your next annual enrollment period or within the first 30 days from the date of your Dependent child's first medical treatment related to his or her disability.

As a new Employee, you may apply for coverage for a disabled Dependent age 26 and over during your initial enrollment period as a new Employee.

Coverage for a Dependent child past age 26 is not guaranteed and is subject to approval by ERS.

COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as defined in Section 13, *Glossary*.

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

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

- a Subscriber;
- a Subscriber's covered Dependent; or
- a Subscriber's covered spouse upon divorce.

Qualifying Events for Continuation Coverage under COBRA

Table 10 describes situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are qualifying events, for purposes of continuation of coverage under COBRA.

TABLE 10			
If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA for the following maximum periods:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced ¹	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months

TABLE 10			
You or your Dependent becomes eligible for Social Security disability benefits at any time within the first 60 days of losing coverage ²	Up to 29 months	Up to 29 months	Up to 29 months
You die	N/A	36 months	36 months
You divorce	N/A	36 months	36 months ³
Your child is no longer an eligible Dependent (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See Table 11	See Table 11

¹This can be a qualifying event under COBRA only for Employees of Institutions of Higher Education covered under the Plan. The specific Institution of Higher Education determines the number of hours in a month an Employee must work to be eligible for coverage under the Plan. When the number of hours is decreased so that the Employee is not eligible for coverage under the Plan, then this a qualifying event under COBRA.

²Subject to the following conditions: (i) the Qualified Beneficiary must give ERS notice of the disability not later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided to ERS within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

³This period applies to children who lose coverage due to the divorce. If the former spouse's children were covered under the Plan, they will lose coverage and may elect coverage under COBRA. The COBRA election does not apply to the Subscriber's children who continue to be eligible for coverage as the Subscriber's Dependents.

Note: While some Qualifying Life Events as described in Section 2, *Introduction*, are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed in that section.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

Table 11 below outlines how your Dependents' COBRA coverage is impacted if you become eligible for Medicare.

TABLE 11	
If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become eligible for Medicare and don't experience any additional qualifying events	36 months
You become eligible for Medicare, after which you experience a second qualifying event ¹ before the initial 18-month period expires	36 months

TABLE 11	
If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You experience a qualifying event ¹ , after which you become eligible for Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare eligibility would have resulted in loss of Dependent coverage under the Plan	36 months

¹For example, your employment is terminated for reasons other than gross misconduct.

Getting Started

ERS will notify you by mail if you become eligible for COBRA coverage. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Subscriber and Dependent costs, if applicable, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 105 days from the date you receive notification or from the date your coverage ends, whichever is later, to elect and pay the cost of your COBRA coverage. The payment must include the monthly cost for all months retroactive to the date your Plan coverage ended.

During the 105-day election period, the Plan will, only if you request, inform the Provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a Participant in the Plan under COBRA, you have the right to change your coverage election:

- during Annual Enrollment; and
- following a Qualifying Life Event, as described under *Changing Your Coverage* in Section 2, *Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce or loss of Dependent status, you or your Dependents must notify the ERS or your Benefit Coordinator within 60 days of the latest of:

- the date of the divorce or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify ERS when a secondary qualifying event occurs that will extend continuation coverage under COBRA.

If you or your Dependents fail to notify ERS of these events within the 60 day period, the Plan is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are

continuing coverage under COBRA, you must also notify ERS within 31 days of any Qualifying Life Event.

Once you have notified ERS, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide ERS with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to ERS at the address stated in Section 14, *Important Administrative Information*. The contents of the notice must be such that ERS is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

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

If a Subscriber qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact ERS for additional information. The Subscriber must contact ERS promptly after qualifying for assistance under the Trade Act of 1974 or the Subscriber will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

When COBRA Ends

COBRA coverage will end, before the maximum continuation period, on the earliest of the following dates:

- the date, after electing continuation coverage, that coverage is first obtained under any other group health plan;
- the date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare;
- the date coverage ends for failure to make the required premium payment; or
- the date coverage would otherwise terminate under the Plan as described in the beginning of this section.

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

Uniformed Services Employment and Reemployment Rights Act

A Subscriber who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Subscriber and the Subscriber's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Subscribers may elect to continue coverage under the Plan by notifying their Employer in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Employer normally pays on a Subscriber's behalf. If a Subscriber's Military Service is for a period of time less than 31 days, the Subscriber may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

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

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

Regardless of whether a Subscriber continues health coverage, if the Subscriber returns to a position of employment that is eligible for participation in the GBP, the Subscriber's health coverage and that of the Subscriber's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Subscriber or the Subscriber's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call your Benefits Coordinator if you have questions about your rights to continue health coverage under USERRA.

SECTION 12 - OTHER IMPORTANT INFORMATION

What this section includes:

- Qualified Medical Child Support Orders;
- Your relationship with UnitedHealthcare and the Employees Retirement System of Texas;
- Relationships between Providers, UnitedHealthcare and HealthSelect;
- Interpretation of the Plan;
- Records; and
- How to access the Plan document.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a National Medical Support Order for your child that instructs the Plan to cover the child, your Benefits Coordinator will review it to determine if it meets the requirements for a QMCSO. If it is determined that it does, and your child meets the definition of an eligible Dependent, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as provided under the Plan.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and the Employees Retirement System of Texas

In order to make choices about your health care coverage and treatment, it is important for you to understand how UnitedHealthcare interacts with the Plan and how it may affect you. The ERS Board of Trustees has contracted with UnitedHealthcare as a third-party administrator of the Plan to assist in the administration of the Plan. Neither ERS nor UnitedHealthcare provides medical services or makes treatment decisions.

UnitedHealthcare processes claims for Benefits and communicates with you regarding decisions about whether the Plan will cover the health care that you may receive. The Plan pays for Covered Health Services, which are more fully described in this MBPD.

UnitedHealthcare is not an employer or employee of ERS for any purpose with respect to the administration or provision of Benefits under this Plan.

Relationships Between Network Providers, UnitedHealthcare and HealthSelect

The relationships between UnitedHealthcare and Network Providers are solely contractual relationships between independent contractors. Network Providers are not agents or employees of ERS, HealthSelect or UnitedHealthcare. ERS and its employees are not agents or employees of Network Providers, nor are UnitedHealthcare and its employees agents or employees of Network Providers.

UnitedHealthcare arranges for health care Providers to participate in the HealthSelect Network and administers the HealthSelect Plan, on behalf of ERS subject to ERS' oversight. Network Providers are independent practitioners who run their own offices and Facilities. UnitedHealthcare's credentialing process confirms public information about the Providers' licenses and other credentials, but does not assure the quality of the services provided. ERS and UnitedHealthcare do not have any other relationship with Network Providers. ERS and UnitedHealthcare are not liable for any act or omission of any Provider in caring for any Participant receiving health care services covered under the Plan.

Your Relationship with Providers

The relationship between you and any Provider is that of Provider and patient. Your Provider is solely responsible for the quality of the health care goods and services provided to you. You are responsible for:

- choosing your own Provider;
- paying, directly to your Provider, any amount identified as a Participant's responsibility, including Copayments, Coinsurance, any Annual Deductible, other deductibles and any amount a Non-Network Provider charges that exceeds Eligible Expenses;
- paying, directly to your Provider, the cost of any health care service not covered by the Plan;
- deciding if each Provider treating you is right for you (this includes Network and Non-Network Providers you choose as well as Providers to whom you have been referred); and
- deciding with your Provider what care you should receive, even if it is not covered under the Plan.

Interpretation of the Plan

ERS has discretion to interpret Plan provisions including this MBPD and any Amendment or Addendum.

ERS has delegated to UnitedHealthcare the discretion to determine whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan, according to guidelines established by the Plan and/or UnitedHealthcare.

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

Records

All Participant records that are in the custody of ERS or UnitedHealthcare are confidential and not subject to public disclosure under Chapter 552, Texas Government Code, Section 1551.063, Texas Insurance Code, and the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

For complete listings of your medical records or billing statements, UnitedHealthcare recommends that you contact your health care Provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms. If you request medical forms or records from UnitedHealthcare, it also may charge you reasonable fees to cover costs for completing the forms or providing the records.

How to Access the Plan Document

A copy of this Master Benefit Plan Document and other Plan information may be downloaded from **www.healthselectoftexas.com**. You may also request a copy of this Master Benefit Plan Document by making a written request to ERS. The copy will be provided for a reasonable charge within 30 days of its receipt of the request.

SECTION 13 - GLOSSARY

What this section includes:

- Definitions of terms used throughout this Master Benefit Plan Document (MBPD).

Many of the terms used throughout this MBPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this MBPD, but it does not describe the Benefits provided by the Plan.

Act – the Texas Employees Group Benefits Act (Texas Insurance Code, Chapter 1551).

Actively at Work, Actively Working, Active Work, Active Service or Active Duty – the active expenditure of time and energy in the service of the Employer, including elected officials of the State who are eligible for coverage under the Act. An Employee will be considered to be on Active Duty on each day of a regular paid vacation or regular paid sick leave, or on a regular non-working day, provided he was Actively at Work on the last preceding work-day.

Addendum – an attached written description of additional or revised provisions to the Plan. The Benefits and exclusions of this Master Benefit Plan Document and any Amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and Master Benefit Plan Document and/or Amendments to the Master Benefit Plan Document, the Addendum shall be controlling.

Additional Deductible – the amount you must pay if you do not obtain Prior Authorization before you are admitted for an Inpatient Stay, whether for medical, mental health or substance-related and addictive disorder treatment. The Additional Deductible is \$200 and applies each time you fail to obtain Prior Authorization for an Inpatient Stay as required.

Affordable Care Act (ACA) – federal law that includes the Patient Protection and Affordable Care Act (Public Law 111-148; March 23, 2010; 124 Stat. 119) and the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152; March 30, 2010; 124 Stat. 1029). This is also referred to as the federal health care reform statute.

Allowable Amount – see Eligible Expenses.

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

- surgical services;
- Emergency Health Services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance Use Disorder Services on an Outpatient basis or Inpatient basis (for example a Residential Treatment Facility).

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

Annual Enrollment – the period of time during which eligible Subscribers may enroll themselves and their Dependents in the Plan. ERS determines the period of time that is the Annual Enrollment period.

Annual Deductible (or Deductible) – the amount you must pay for Covered Health Services in a Calendar Year before the Plan will begin paying Benefits in that Calendar Year. The Deductibles are shown in Table 2 in Section 5, *Schedule of Benefits and Coverage*.

Applied Behavioral Analysis – intensive behavioral therapy, given by a board certified behavioral analyst or other special Provider, which consists of a series of behavioral and/or Educational habilitative interventions for the treatment of Autism Spectrum Disorders.

Authorized Representative – a person authorized to act on behalf of a Participant. This does not include a Provider or other entity acting as an assignee of a Participant's claim. See Authorized Representative in Section 8, *Claims Procedures*, for information on how to properly designate an Authorized Representative. An Authorized Representative must be properly designated in order to protect against improper disclosure of information about a Participant including protected health or other confidential information.

Autism Spectrum Disorders – a neurodevelopmental disorder marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Bariatric Deductible – the amount an Employee must pay for bariatric surgery before he or she is eligible to begin receiving Network Benefits for such surgery. There is no coverage for bariatric surgery provided by a Non-Network Provider. The Bariatric Deductible is shown in Table 3 in Section 5, *Schedule of Benefits and Coverage*, under *Bariatric Surgery*.

Bariatric Resource Services (BRS) – a program administered and made available to you by UnitedHealthcare or its affiliates. The BRS program provides:

- specialized clinical consulting services to Participants to educate on obesity treatment options; and
- access to specialized Center of Excellence Network Facilities and Physicians for bariatric surgery services.

Benefits – Plan payments for Covered Health Services, subject to the Act, the ACA, the Rules of the ERS Board of Trustees, the terms and conditions of the Plan and any Addendums and/or Amendments.

Benefits Coordinator – a person employed by your Employer to provide assistance for Participants with various benefit programs, including the Plan. ERS is the Benefits Coordinator for Retirees.

Body Mass Index (BMI) – a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

BMI – see Body Mass Index (BMI).

BRS – See Bariatric Resource Services

Calendar Year – the annual period of time from January 1 to December 31, inclusive, as distinguished from Plan Year which is from September 1 through August 31, inclusive.

Cancer Resource Services (CRS) – a program administered and made available to you by UnitedHealthcare or its affiliates. The CRS program provides:

- specialized consulting services, on a limited basis, to Participants with cancer;
- access to cancer centers with expertise in treating the most rare or complex cancers; and
- education to help Participants understand their cancer and make informed decisions about their care and course of treatment.

Center of Excellence – a Facility that has entered into an agreement with UnitedHealthcare to provide Covered Health Services for the treatment of specific diseases or conditions. A Center of Excellence may or may not be located within the Plan Service Area.

To be considered a Center of Excellence, a Facility must meet certain standards of excellence and have a proven track record of treating specific conditions as determined by UnitedHealthcare.

CHD – see Congenital Heart Disease (CHD).

Chiropractic Treatment – the therapeutic application of chiropractic treatment and/or manipulative treatment with or without ancillary physical therapy and/or rehabilitative methods rendered to restore or improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Clinical Trial – a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the Participant is not allowed to choose which treatment he or she will receive.

COBRA – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance – the percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*. The percentage of Eligible Expenses paid by the Plan for Covered Health Services is shown in Table 3 in Section 5, *Schedule of Benefits and Coverage*.

Complications of Pregnancy – complications (when Pregnancy is not terminated) for which diagnoses are distinct from Pregnancy but adversely affected or caused by Pregnancy, such as nephritis, cardiac decompensation and miscarriage. It does not include false labor, occasional spotting, physician prescribed rest during Pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, eclampsia, and similar conditions associated with Pregnancy not constituting a nosologically distinct complication of Pregnancy. Covered Health Services for Complications of Pregnancy do not include services and supplies provided at termination of Pregnancy.

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

Congenital Heart Disease (CHD) – any structural heart condition or abnormality that has been present since birth. Congenital heart disease may:

- be passed from a parent to a child (inherited);
- develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; or
- have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – a federal law that requires employers to offer continued health insurance coverage at the insured's expense to certain Employees and their Dependents whose group health insurance has been terminated.

Convenience Care Clinic (formerly known as Retail Health Clinic) – health care clinic located in a retail setting, such as a supermarket or pharmacy, that provides treatment of common illnesses and routine preventive health care services that can be rendered by appropriately licensed Providers located in the clinic.

Copayment (or Copay) – the set dollar amount you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Cosmetic Procedures – procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Plan. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in a function, e.g., breathing.

Cost-Effective – the least expensive item or service that performs the necessary function. This term applies to Durable Medical Equipment, prosthetic devices and certain other Covered Health Services.

Covered Health Services – those health services, supplies and Pharmaceutical Products, which the Plan determines to be:

- Medically Necessary;
- included in Sections 5 and 6, *Schedule of Benefits and Coverage and Details for Covered Health Services*, described as a Covered Health Service;
- provided to a Participant who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and
- not identified in Section 7, *Exclusions: What the Medical Plan Will Not Cover*, as not covered.

CRS – see Cancer Resource Services (CRS).

Custodial Care – services that do not require special skills or training and that:

- provide assistance in activities of daily living (including, but not limited to, feeding or cooking, dressing, going to the toilet, preventive and pain-relieving skin care, bathing, ostomy care, incontinence care, checking of routine vital signs and ambulating or exercising functions);
- are provided for the primary purpose of meeting the personal needs of the Participant or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Declaration of Informal Marriage – a document that memorializes that a man and a woman desire to consider themselves married for all legal purposes. The completed document requires the notarized signatures of both parties and must be filed with the District Clerk of the county of the couple's residence.

Deductible – see Annual Deductible.

Dependent – an individual who, because of a statutorily defined relationship with a Subscriber, meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*, and is enrolled as a Participant in the Plan. A Dependent does not include anyone who is enrolled in the Plan as a Subscriber. No one can be enrolled as a Dependent of more than one Subscriber.

DME – see Durable Medical Equipment (DME).

Domiciliary Care – a supervised living arrangement in a home-like environment, providing assistance with activities of daily living, for Participants who are unable to live independently because of age-related impairments or physical, mental or visual disabilities.

Durable Medical Equipment (DME) – any medical equipment appropriate for use in the home to aid in a better quality of living for Participants with a Sickness, Injury or disability, and that meets the requirements specified under *Durable Medical Equipment (DME)* in Section 6, *Details for Covered Health Services*.

Educational – services, supplies, and related expenses provided to address a Participant’s developmental delays, or otherwise provide training, skills, practice and exercises designed to enhance academic performance, to teach positive behaviors and/or discourage inappropriate, destructive or otherwise negative conduct. It includes, but is not limited to, special education or conventional learning techniques, Applied Behavioral Analysis in any form, operant conditioning or other forms of training.

Eligible Expenses – (sometimes known as the Allowable Amount). For Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in Section 3, *How the Plan Works*.

Eligible Expense determinations are subject to UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare’s discretion, following evaluation and validation of all Provider billings in accordance with one or more of the following methodologies:

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

Emergency – a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, or substance-related and addictive disorder which:

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

The Plan determines if a medical condition is an Emergency based on factors that include, but are not limited to, medical information supplied by the Participant’s Provider.

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

Employee – an appointive or elective state officer (including a judicial officer) or employee in the service of the state of Texas, including an employee of an Institution of Higher Education, as defined in Section 1551.003 of the Act and in this *Glossary*, and any persons required or permitted by the Act to enroll as Subscribers. Eligibility for participation in the Plan for Employees is limited to the specific statutes that include them as Employees. This definition does not infer any greater eligibility for or right of access to the Benefits provided by this Plan than the statutes establishing each class of eligible persons.

Employer – the state of Texas and all its agencies, certain political subdivisions or Institutions of Higher Education, as defined in this *Glossary*, that employ or employed a Subscriber.

End-Stage Renal Disease (ESRD) – permanent kidney failure, where the kidneys stop working well enough for a Participant to live without dialysis or a kidney transplant.

EOB – see Explanation of Benefits (EOB).

Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorder or other health care services, technologies, supplies, treatments, procedures, drug or other therapies, medications or devices that, at the time the Plan makes a determination regarding coverage in a particular case, the Plan determines 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 I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- routine patient care costs for Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 6, *Details for Covered Health Services*.
- If you are not a participant in a qualifying Clinical Trial as described under *Clinical Trials* in Section 6, *Details for Covered Health Services*, and have a significantly life-threatening Sickness, Injury or other medical condition, ERS, or UnitedHealthcare as its designee, may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness, Injury or other medical condition. Prior to such a consideration, the Plan must first establish, based on good faith medical judgment supported by sufficient scientific evidence that although Experimental or Investigational, the service has significant potential as an effective life-sustaining treatment for that Sickness, Injury or other medical condition.

In making its determination, ERS, or UnitedHealthcare as its designee, will refer to a certification the Participant's Physician must provide stating that he or she, based on good-faith medical judgment, believes:

- the Sickness, Injury or other medical condition is significantly life threatening and imminently fatal if the treatment is limited to Covered Health Services; and
- although designated as Experimental or Investigational, the service has significant potential as an effective life-sustaining treatment for the Sickness, Illness or condition.

In addition to clinical studies regarding the Experimental or Investigational Service, the Plan may consider scientifically grounded standards based on Physician specialty society recommendations and professional standards of care. The Plan reserves the right to obtain expert opinion(s) in determining whether an otherwise Experimental or Investigational Service shall be considered as a Covered Health Service for a particular Sickness, Injury or other medical condition. 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 Plan's sole discretion.

Appeals from a UnitedHealthcare pre-service decision not to consider the Experimental or Investigational Service to be a Covered Health Service will be handled as an appeal of an Urgent Care Request for Benefits under Section 8, *Claims Procedures* of this MBPD.

Explanation of Benefits (EOB) – a statement provided by UnitedHealthcare to you, your Physician, or another health care professional regarding a specific claim for health services or supplies that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance and Copays;
- any other reductions;
- the net amount paid by the Plan;
- the amount you may owe your Provider; and
- the reason(s) why the service or supply was not covered by the Plan.

Facility – a Hospital, Alternate Facility, Inpatient Rehabilitation Facility, Skilled Nursing Facility, Residential Treatment Facility or Urgent Care Center (all as defined in this *Glossary*) or other institution that is licensed to provide services and supplies covered by the Plan and that is approved by UnitedHealthcare. Other Facilities include, but are not limited to:

- substance-related and addictive disorder treatment facilities;
- birthing centers;
- Hospices;
- imaging centers;
- independent laboratories;
- psychiatric day treatment facilities;
- radiation therapy centers; and
- renal dialysis centers.

In states where there is a licensure requirement, other Facilities must be licensed by the appropriate state administrative agency.

Former COBRA Unmarried Child – A child of an Employee or Retiree who is unmarried; whose GBP coverage as a dependent has ceased; and who upon expiration of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act, Public Law 99-272 (COBRA) reinstates GBP coverage.

Genetic Testing – examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Group Benefits Program (GBP or the Program) – the Texas Employees Group Benefits Program as established by the Act and administered by the Employees Retirement System of Texas and its Board of Trustees pursuant to the Act.

HealthSelect of TexasSM Plan or HealthSelect – a self-funded health benefit plan offered through the Group Benefits Program by ERS. It includes an In-Area Plan, an Out-of-Area Plan and a Prescription Drug Program.

Health Statement(s) – a single, integrated statement that summarizes EOB information by providing detailed content regarding account balances and claim activity.

Home Health Agency – a program or organization authorized by law to provide health care services in the home and certified by Medicare as a supplier of Home Health Care.

Hospice – a Facility or agency primarily engaged in providing Hospice care as described in Section 6, *Details for Covered Health Services*, licensed under state law, and certified by Medicare as a supplier of Hospice care.

Hospital – an institution, operated as required by law, that is:

- primarily engaged in providing health care services, on an Inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorder, diagnostic and surgical Facilities, by or under the supervision of a staff of Physicians; and
- has 24 hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care, Domiciliary Care or care of the aged and it is not a Skilled Nursing Facility, convalescent home or similar institution.

In-Area Benefits – Network and Non-Network Benefits that the Plan pays for Covered Health Services received by Subscribers and their Dependents for Subscribers whose eligibility county is in the Plan Service Area.

Injury – bodily damage other than Sickness or disability, including all related conditions and recurrent symptoms.

Inpatient Copayment Maximum – the most you are required to pay each Calendar Year in Copays for Inpatient Stays in a Hospital or for Inpatient care for Mental Health Services, Serious Mental Illness Services or Substance Use Disorder Services. The Inpatient Copayment Maximum amount is shown in Table 2 in Section 5, *Schedule of Benefits and Coverage*. Refer to Section 3, *How the Plan Works*, for a description of how the Inpatient Copayment Maximum works.

Inpatient – a Participant who has been admitted to a Hospital, Nursing Facility or Inpatient Rehabilitation Facility or an Inpatient Facility for Mental Health Services, Serious Mental Illness Services or Substance Use Disorder Services.

Inpatient Rehabilitation Facility – a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an Inpatient basis, as authorized by law.

Inpatient Stay – an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility or an Inpatient Care Facility for Mental Health Services, Serious Mental Illness Services or Substance Use Disorder Services.

Institution of Higher Education – a public junior college, a senior college or university, or any other agency of higher education within the meaning and jurisdiction of Chapter 61, Texas Education Code. It does not include an entity in The University of Texas System, as described in Section 65.02, Texas Education Code and an entity in The Texas A&M University System, as described in Subtitle D, Title 3, Texas Education Code, including the Texas Veterinary Medical Diagnostic Laboratory.

Intensive Outpatient Treatment – a structured Outpatient mental health or substance-related and addictive disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Skilled Nursing Care – skilled nursing care that is provided either for:

- fewer than seven days each week; or
- fewer than eight hours each day for a period of 21 days or less.

The Plan may make exceptions for special circumstances when the need for additional skilled nursing care is finite and predictable.

Kidney Resource Services (KRS) – a program administered and made available to you by UnitedHealthcare or its affiliates. The KRS program provides:

- specialized consulting services to Participants with ESRD or chronic kidney disease;
- access to dialysis centers with expertise in treating kidney disease; and
- guidance for the Participant on the prescribed plan of care.

Marriage and Family Therapy/Counseling – the provision of professional therapy services to individuals, families, or married couples, singly or in groups, involving the professional application of family systems theories and techniques in the delivery of therapy services to those persons. The term includes, but is not limited to, the evaluation and remediation of cognitive, affective, behavioral, or relational dysfunction within the context of marriage or family systems.

Medicaid – a federal program administered and operated individually by participating state and territorial governments and providing health care coverage to eligible low-income people.

Medical Social Services – those social services relating to the treatment of a Participant's medical condition. Such services include, but are not limited to:

- assessment of the social and emotional factors related to the Participant's medical condition, need for care, response to treatment and adjustment to care; and

- assessment of the relationship of the Participant's medical and nursing requirements to the home situation, financial resources, and available community resources.

Medically Necessary, Medical Necessity – health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorder, Serious Mental Illness, or disease (and symptoms), that are all of the following as determined by the Plan. The health care services must be:

- performed 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-related and addictive disorder, Serious Mental Illness, or disease (and symptoms);
- not primarily performed for your comfort or convenience or that of your 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 alternatives with respect to the diagnosis or treatment of your Sickness, Injury, Mental Illness, substance-related and addictive disorder, Serious Mental Illness, or disease (and 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 health care services and positive health outcomes.

If no credible scientific evidence is available, then standards based on Physician specialty society recommendations or professional standards of care may be considered. The Plan 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 Plan's sole discretion.

UnitedHealthcare 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 health services. These clinical policies (as developed by UnitedHealthcare and revised from time to time), are available to Participants at www.myuhc.com/hs or by calling (866) 336-9371 toll-free, and to Physicians and other health care professionals on UnitedHealthcareOnline.

The authority of the Plan to determine Medical Necessity is subject to the right of the Employees Retirement System of Texas Board of Trustees to order payment of a claim even though UnitedHealthcare has not abused its discretion in denying the claim.

Medicare – Parts A, B, C and D of the insurance program for Americans 65 years of age and over as well as younger Americans with certain disabilities, established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Provider - a Provider who is licensed to provide services and/or supplies for treatment of Mental Illness and acts within the scope of that license. Mental Health Providers include, but are not limited to:

- Doctor of Psychology (Psy.D. or Ph.D.) (certified as a health service Provider);

- psychiatrist (M.D.);
- addictionologist (M.D.);
- nurse-practitioner;
- Licensed Clinical Social Worker (LCSW) or Licensed Masters Social Worker – Advanced Practice (LMSW-AP);
- Licensed Marriage and Family Therapist (LMFT);
- licensed professional counselor;
- licensed dependency counselor; and
- licensed psychological associate.

If the Mental Health Provider provides services outside of the Plan Service Area, Mental Health Providers must be licensed by the appropriate state administrative agency where the services are provided.

Mental Health Services – Covered Health Services performed for the diagnosis and treatment of Mental Illnesses, as described in Section 6, *Details for Covered Health Services*. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Use Disorder Administrator – the organization or individual designated by UnitedHealthcare who provides or arranges Mental Health, Serious Mental Illness and Substance Use Disorder Services under the Plan.

Mental Illness – mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, or any other diagnostic coding system as used by the Plan, whether or not the cause of the disease, disorder or condition is physical, chemical, or mental, in nature or origin, unless the service or diagnostic category is listed in Section 7, *Exclusions: What the Medical Plan Will Not Cover*.

Neonatal Resource Services (NRS) - a program administered and made available to you by UnitedHealthcare or its affiliates. The NRS program provides guided access to a network of credentialed neonatal intensive care unit (NICU) Providers and specialized nurse consulting services to help manage NICU admissions.

Network – (sometimes referred to as HealthSelect Network) a nationwide system of Providers developed by UnitedHealthcare or its affiliate to provide Covered Health Services to Participants in the Plan. Each Network Provider has a participation agreement in effect (either directly or indirectly) with UnitedHealthcare or with its affiliate to participate in the Network. UnitedHealthcare's affiliates are those entities affiliated with UnitedHealthcare through common ownership or control with UnitedHealthcare or with UnitedHealthcare's ultimate corporate parent, including direct and indirect subsidiaries.

A Provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network Provider for only certain products. In this case, the Provider will be a Network Provider for the Covered Health Services and products included in the participation agreement, and a Non-Network Provider for other Covered Health Services and products. The participation status of Providers may change from time to time. You may find out the services for which a Provider is a Network Provider by calling UnitedHealthcare at (866) 336-9371 toll-free.

Network Benefits - Benefits that the Plan pays for Covered Health Services provided by Network Providers. Refer to Section 5, *Schedule of Benefits and Coverage*, for details about how Network Benefits apply.

Non-Network – when used to describe a Provider of health care services, this means a Provider outside of the Network as established and maintained by UnitedHealthcare.

Non-Network Benefits - description of how Benefits are paid for Covered Health Services provided by Non-Network Providers. Refer to Section 5, *Schedule of Benefits and Coverage*, for details about how Non-Network Benefits apply.

Out-of-Area – describes the part of the HealthSelect Plan that is available to Participants whose eligibility county is outside the Plan Service Area or who are Retirees 65 years of age or over and their Dependents.

Out-of-Pocket Coinsurance Maximum – the most you are required to pay each Calendar Year for Coinsurance. Refer to Section 5, *Schedule of Benefits and Coverage*, for the Out-of-Pocket Coinsurance Maximum amount. Refer to Section 3, *How the Plan Works*, for a description of how the Out-of-Pocket Coinsurance Maximum works.

Outpatient – a Participant who has been treated at a Hospital or Facility for other than Inpatient treatment.

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

Participant – an Employee, Retiree, or a Dependent, as defined in the Act, and surviving Dependents of deceased Employees and Retirees, or other persons eligible for coverage as provided under the Act while eligible for coverage and enrolled under the Plan. References to "you" and "your" throughout this Master Benefit Plan Document are references to a Participant.

Participating – (also known as Par) see Network in *Glossary*.

Personal Health Support – programs provided by UnitedHealthcare that are designed to encourage an efficient system of care for you. The programs focus on prevention, education, and closing gaps in health care services. You may contact Personal Health Support by calling (866) 336-9371 toll-free

Personal Health Support Nurse – the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Products – U.S. Food and Drug Administration (FDA)-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care Provider within the scope of the Provider's license, and not otherwise excluded under the Plan. Pharmaceutical Products do not include medications that are typically available by prescription order or refill at a pharmacy under the HealthSelect Prescription Drug Program through Caremark or the HealthSelect Medicare Rx plan through SilverScript.

Physician – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please note: The fact that a Provider is described as a Physician does not mean that Benefits for services from that Provider are available to you under the Plan.

Plan – the HealthSelect of Texas Comprehensive Medical Care (Out-of-Area) Plan.

Plan Administrator – the Employees Retirement System of Texas (ERS) or its designee.

Plan Service Area – the geographical area or areas designated by the Employees Retirement System of Texas Board of Trustees as the area in which In-Area Benefits are available. See Section 2, *Introduction*, for more details.

Post-Service Claim - a claim for Benefits that is not a Pre-Service Request for Benefits or Urgent Care Request for Benefits. Post-Service Claims include claims that involve only the payment or reimbursement of Eligible Expenses for Covered Health Services that have already been provided.

Preauthorization or Predetermination – See Prior Authorization.

Pregnancy – includes, but is not limited to, prenatal care, postnatal care and childbirth. Complications of Pregnancy are considered separately as defined in this section.

Pre-Service Request for Benefits – a claim for Benefits where the Plan conditions receipt of the Benefit, in whole or in part, on approval of the Benefit in advance of obtaining medical care. This includes Covered Health Services which the Plan must approve or for which you must obtain Prior Authorization from UnitedHealthcare before non-Urgent Care is provided.

Primary or Primary Plan - when you are covered by more than one health benefits plan, the Primary Plan is the plan that pays benefits first under coordination of benefits (COB) guidelines. Remaining Eligible Expenses may be paid under the other plan, which is called the Secondary Plan. Refer to Section 9, *Coordination of Benefits (COB)*, for details on COB guidelines.

Prior Authorization – (sometimes known as preauthorization or predetermination) the utilization review process that the Plan uses to determine whether certain services are Covered Health Services under the Plan. See Section 4, *Prior Authorization*, for the list of services requiring Prior Authorization and for details on the Prior Authorization process.

Private Duty Nursing – shift or continuous nursing care that encompasses nursing services for Participants who require more individual and continuous care than is available from a visiting nurse through a Home Health Agency. Private Duty Nursing services are provided where longer durations of Skilled Care are required and may include shift care or continuous care 24 hours a day, 7 days a week in certain settings. Private Duty Nursing care is not care provided primarily for the comfort or convenience of the Participant.

Program – See Group Benefits Program (GBP).

Provider – a Facility, Hospital, Physician or Mental Health Provider (all as defined in this section) or other Provider that is licensed to provide health care services and supplies and acts within the scope of that license and that is approved by UnitedHealthcare. Other Providers include, but are not limited to, the following when acting within the scope of his or her license:

- Doctor of Chiropractic;
- Doctor of Medical Dentistry;
- Doctor of Dental Surgery;
- podiatrist;
- licensed audiologist;

- licensed dietitian;
- licensed hearing aid fitter and dispenser;
- licensed speech, physical or occupational therapist;
- Christian Science Practitioner;
- optometrist or ophthalmologist;
- Physicians' Assistant;
- advanced practice nurse;
- licensed surgical assistant;
- Nurse-Anesthetist;
- DME/prosthetics Provider;
- Home Health Agency;
- Network home infusion therapy Provider; and
- Convenience Care Clinic.

In states where there is a licensure requirement, other Providers must be licensed by the appropriate state administrative agency.

Qualifying Life Event (QLE) – a life experience whose occurrence allows a Participant to change health care coverage during a Plan Year, provided that the change in coverage is consistent with the life event. See *Changing Your Coverage* in Section 2, *Introduction*, for a list of Qualifying Life Events and how to change your coverage.

Reconstructive Procedure – a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include, but are not limited to, surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary intended result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the condition does not classify surgery or any other procedure done to relieve the condition as a Reconstructive Procedure.

Residential Treatment Facility – a Facility that provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and meets all of the following requirements:

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

- counseling; and
- referral and orientation to specialized community resources.

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

Retiree – (also known as annuitant) an Employee who has retired as defined in the Act.

Secondary or Secondary Plan - when you are covered by more than one health benefits plan, the Secondary Plan is the plan that pays benefits second, following the Primary Plan, under coordination of benefits (COB) guidelines. The Secondary Plan may or may not pay all remaining Eligible Expenses after the Primary Plan has paid, depending on how COB is determined. Refer to Section 9, *Coordination of Benefits (COB)*, for details on COB guidelines.

Semi-private Room - a room with two or more beds.

Serious Mental Illness - the following psychiatric illnesses as defined in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*:

- schizophrenia;
- paranoid and other psychotic disorders;
- bipolar disorders (hypomanic, manic, depressive, and mixed);
- major depressive disorders (single episode or recurrent);
- schizo-affective disorders (bipolar or depressive);
- pervasive developmental disorders;
- obsessive-compulsive disorders; and
- depression in childhood and adolescence.

Sickness – physical illness, disease or Pregnancy. The term Sickness as used in this MBPD includes Mental Illness and substance-related and addictive disorder, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care – skilled nursing, skilled teaching, and skilled rehabilitation services when:

- they are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the Participant;
- a Physician orders them;
- they are not delivered for the purpose of assisting with activities of daily living, including, but not limited to, dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility – a nursing Facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

State Agency – a commission, board, department, division, Institution of Higher Education, or other agency of the state of Texas created by the constitution or statutes of this state. This term

also includes the Texas Municipal Retirement System, the Texas County and District Retirement System, the Teachers Retirement System and ERS.

Subscriber – the Participant who is the Employee, Retiree, or other person enrolled in the Plan as provided for under the Act, and who is not a Dependent.

Substance Use Disorder (Chemical Dependency) Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorder that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded by the Plan. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Health Service.

Telehealth and Telemedicine - the use of interactive audio, video, other electronic media or advanced telecommunications technology to provide health services. The term includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education. Telehealth also includes 1) compressed digital interactive video, audio, or data transmission; 2) clinical data transmission using computer imaging by way of still image capture and store and forward; and 3) other technology that facilitates access to health care services or medical specialty expertise. The term does not include services performed using a telephone or facsimile machine.

Total Out-of-Pocket Maximum – the most you are required to pay each Calendar Year for Coinsurance, Copays and applicable Deductibles, as detailed in Section 5, *Schedule of Benefits and Coverage*. Refer to Section 3, *How the Plan Works*, for a description of how the Out-of-Pocket Maximum works.

Transitional Care – Mental Health Services/Substance Use Disorder Services that are provided through transitional living Facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- sober living arrangements such as drug-free housing and alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Participant with recovery; or
- supervised living arrangements that are residences such as transitional living Facilities, group homes and supervised apartments that provide Participants with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment does not offer the intensity and structure needed to assist the Participant with recovery.

UnitedHealth Premium ProgramSM – a program that identifies Network Physicians that have been designated as a UnitedHealth Premium ProgramSM Physician for certain medical conditions.

To be designated as a UnitedHealth PremiumSM Provider, Physicians must meet program criteria. The fact that a Physician is a Network PhysicianSM does not mean that it is a UnitedHealth Premium ProgramSM Physician.

UnitedHealthcare – the company that, with its affiliates, provides certain claim administration services for the Plan on behalf of the Plan Administrator. UnitedHealthcare is also known as United HealthCare Services, Inc.

United Resource Networks – an affiliate of UnitedHealthcare that provides access to Centers of Excellence Networks for specific conditions, including transplants, cancer and Congenital Heart Disease.

Unproven Services – health services, including medications, that have not been determined to be effective for treatment of the Sickness, Injury or other medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com/hs.

Please note: If you have a significantly life-threatening Sickness, Injury or other medical condition, ERS, or UnitedHealthcare as its designee may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness, Injury or other medical condition. Prior to such a consideration, the Plan must first establish, based on good faith medical judgment supported by sufficient scientific evidence, that albeit unproven, the service has significant potential as an effective life-sustaining treatment for that Sickness, Injury or other medical condition.

To be considered for this exception, the Participant's physician must certify, based on good faith medical judgment, that:

- the Sickness, Injury or other medical condition is significantly life threatening and imminently fatal if the treatment is limited to Covered Health Services; and
- although designated as Experimental or Investigational, the service has significant potential as an effective life-sustaining treatment for the Sickness, Illness or condition.

In addition to clinical studies regarding the Unproven Service, the Plan may consider scientifically grounded standards based on Physician specialty society recommendations and professional standards of care. The Plan reserves the right to obtain expert opinion(s) in determining whether an otherwise Unproven Service shall be considered as a Covered Health Service for a particular Sickness, Injury or other medical condition. 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 Plan's sole discretion.

Appeals from an ERS or UnitedHealthcare decision not to consider the Experimental or Investigational Service to be a Covered Health Service will be handled as an appeal of an Urgent Care Request for Benefits under Section 8, *Claims Procedures* of this Master Benefit Plan Document.

Urgent Care – treatment of an unexpected Sickness or Injury that is not life-threatening but requires Outpatient medical care that cannot be postponed. An urgent situation requires prompt

medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Urgent Care Center – a Facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- do not require an appointment;
- are open outside of normal business hours, so you can get medical attention for a minor Sickness or Injury that occurs at night or on weekends; and
- provide an alternative to an Emergency room if you need immediate medical attention, but your Physician cannot see you right away.

Urgent Care Request for Benefits – a claim for medical care or treatment with respect to which application of the time periods for making non-urgent determinations (a) could seriously jeopardize the life or health of the Participant or the ability of the Participant to regain maximum function, or (b) in the opinion of the Participant’s Physician, would subject the Participant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

SECTION 14 - IMPORTANT ADMINISTRATIVE INFORMATION

What this section includes:

- Plan administrative information.

This section includes information on the administration of the Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Administrator: The Plan Administrator is the Employees Retirement System of Texas (ERS). ERS may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of administrative services including arrangement of access to a Network Provider; claims processing and payment services, including coordination of Benefits and subrogation; utilization management and complaint resolution assistance. This contracted administrator for the Plan is the claims administrator, United HealthCare Services, Inc. For Benefits as described in this MBPD, ERS also has selected a Provider Network established by United HealthCare Services, Inc.

The Employees Retirement System of Texas
200 East 18th Street
Austin, TX 78701

(877) 275-4377

ERS retains all fiduciary responsibilities with respect to the Plan except to the extent ERS has allocated to other persons or entities one or more fiduciary responsibility(s), as it has to United HealthCare Services, Inc., with respect to the Plan.

Claims Administrator: The company that provides certain administrative services for the Plan described in this MBPD.

United HealthCare Services, Inc.
185 Asylum St.
Hartford, CT 06103-3408

(866) 336-9371

UnitedHealthcare shall not be deemed or construed as an Employer for any purpose with respect to the administration or provision of Benefits under the Plan. UnitedHealthcare shall not be responsible for fulfilling any duties or obligations of an Employer with respect to the Plan.

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("ACA")

Patient Protection Notices

HealthSelect encourages the designation of a primary care provider. You have the right to designate any primary care provider who participates in UnitedHealthcare's Network and who is available to accept you or your covered family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact UnitedHealthcare at (866) 336-9371 toll-free.

You may designate a pediatrician as the primary care provider for children, a gynecologist or obstetrician for women, or for any Participants (including children and women), a Physician in the Network who has a majority of his or her practice in internal medicine, family practice, or general medicine.

You do not need Prior Authorization from UnitedHealthcare or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in UnitedHealthcare's Network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a more information regarding Prior Authorizations see *Section 4, Prior Authorizations*.

ATTACHMENT II - THE EMPLOYEES RETIREMENT SYSTEM OF TEXAS SUMMARY NOTICE OF PRIVACY PRACTICES

The Employees Retirement System of Texas (“ERS”) administers the Texas Employees Group Benefits Program, including your health plan, pursuant to Texas law. THIS NOTICE DESCRIBES HOW ERS MAY USE OR DISCLOSE MEDICAL INFORMATION ABOUT YOU AND HOW YOU CAN GET ACCESS TO YOUR OWN INFORMATION PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (“HIPAA”) PRIVACY RULE. PLEASE REVIEW THIS NOTICE CAREFULLY.

Uses and Disclosures of Health Information:

ERS and/or a third-party administrator under contract with ERS may use health information about you on behalf of your health plan to authorize treatment, to pay for treatment, and for other allowable health care purposes. Health care providers submit claims for payment for treatment that may be covered by the group health plan. Part of payment includes ascertaining the medical necessity of the treatment and the details of the treatment or service to determine if the group health plan is obligated to pay. Information may be shared by paper mail, electronic mail, fax, or other methods.

By law, ERS may use or disclose identifiable health information about you without your authorization for several reasons, including, subject to certain requirements, for public health purposes, for auditing purposes, for research studies, and for emergencies. ERS provides information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, ERS will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. ERS cannot use or disclose your genetic information for underwriting purposes. ERS may change its policies at any time. When ERS makes a significant change in its policies, ERS will change its notice and post the new notice on the ERS website at www.ers.state.tx.us. Our full notice is available at http://www.ers.state.tx.us/about/legislation/documents/hipaa_longform.pdf.

For more information about our privacy practices, contact the ERS Privacy Officer. ERS originally adopted its Notice of Privacy Practices and HIPAA Privacy Policies and Procedures Document April 14, 2003, and subsequently revised them effective February 17, 2010, and September 23, 2013.

Individual Rights:

In most cases, you have the right to look at or get a paper or electronic copy of health information about you that ERS uses to make decisions about you. If you request copies, we will charge you the normal copy fees that reflect the actual costs of producing the copies including such items as labor and materials. For all authorized or by law requests made by others, the requestor will be charged for production of medical records per ERS' schedule of charges. You also have the right to receive a list of instances when we have disclosed health information about you for reasons other than treatment, payment, healthcare operations, related administrative purposes, and when you explicitly authorized it. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that ERS correct the existing information or add the missing information. You have the right to request that ERS restrict the use and disclosure of your health information above what is required by law. If ERS accepts your request for restricted use and disclosure then ERS must abide by the request and may only reverse its position after you have been appropriately notified. You have the right to request an alternative means of communications with ERS. You are not required to explain why you want the alternative means of communication.

Complaints:

If you are concerned that ERS has violated your privacy rights, or you disagree with a decision ERS has made about access to your records, you may contact the ERS Privacy Officer. You also may send a written complaint to the U.S. Department of Health and Human Services. The ERS Privacy Officer can provide you with the appropriate address upon request.

Our Legal Duty:

ERS is required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this Notice, and obtain your acknowledgement of receipt of this Notice.

Detailed Notice of Privacy Practices:

For further details about your rights and the federal Privacy Rule, refer to the detailed statement of this Notice. You can ask for a written copy of the detailed Notice by contacting the Office of the Privacy Officer or by visiting ERS' web site at www.ers.state.tx.us. If you have any questions or complaints, please contact the ERS Privacy Officer by calling (512) 867-7711 or toll-free (877) 275-4377 or by writing to ERS Privacy Officer, The Employees Retirement System of Texas, P.O. Box 13207, Austin, TX 78711-3207.

ADDENDUM - LIST OF COVERED PREVENTIVE CARE SERVICES

Preventive services that are currently rated as A or B according to the United States Preventive Services Task Force (USPSTF) are listed below. This list is subject to change according to the guidelines and recommendation provided by USPSTF. Coverage is subject to guidelines based on age, risk factors, dosage, and frequency.

Under the Affordable Care Act, certain preventive health services are paid at 100% (i.e., at no cost to the participant) conditioned upon physician billing and diagnosis. In some cases, you may be responsible for payment on certain related services that are not guaranteed payment at 100% by the Affordable Care Act.

For details on covered preventive services, visit the UnitedHealthcare preventive care website at <http://uhcpreventivecare.com/>.

List of Covered Preventive Care Services		
Children	Adults	
Newborns <ul style="list-style-type: none"> ■ Screening for hearing loss, hypothyroidism, sickle cell disease, and phenylketonuria (PKU) ■ Gonorrhea preventive medication for eyes 	General Health Screenings <ul style="list-style-type: none"> ■ Blood pressure screening ■ Cholesterol screening ■ Type 2 diabetes screening ■ HIV, HPV and STI screenings ■ Hepatitis B screening ■ Hepatitis C screenings ■ Obesity screening and counseling 	Men <ul style="list-style-type: none"> ■ Abdominal aortic aneurysm one-time screening
Immunizations <ul style="list-style-type: none"> ■ Diphtheria, Tetanus, Pertussis ■ Haemophilus influenzae type B ■ Hepatitis A and B ■ Human Papillomavirus (HPV) ■ Influenza (Flu) ■ Measles, Mumps, Rubella ■ Meningococcal ■ Pneumococcal (pneumonia) ■ Inactivated Poliovirus ■ Rotavirus ■ Varicella (chicken pox) 	Cancer Screenings <ul style="list-style-type: none"> ■ Breast cancer mammography ■ Breast cancer chemoprevention counseling ■ Cervical cancer pap test for women* ■ Colorectal cancer screenings including fecal occult blood testing, sigmoidoscopy, or colonoscopy* ■ Prostate cancer (PSA) screening for men ■ Lung cancer screening 	Women <ul style="list-style-type: none"> ■ Osteoporosis screening ■ Chlamydia infection screening ■ Gonorrhea and syphilis screening ■ BRCA Genetic Testing and counseling ■ Breast cancer preventive medications ■ Contraceptive methods and counseling

*The HealthSelect Plan does not impose the age limitations outlined in the current USPSTF guidelines.

List of Covered Preventive Care Services		
Children	Adults	
<p>General Health Screenings</p> <ul style="list-style-type: none"> ■ Medical history for all children throughout development ■ Height, weight, and Body Mass Index (BMI) measurements ■ Developmental screening ■ Autism screening* ■ Behavioral assessment ■ Visual acuity screening ■ Oral health risk assessment ■ Dental caries prevention ■ Hematocrit or hemoglobin screening ■ Obesity screening and weight management counseling ■ Lead screening ■ Dyslipidemia screening ■ Tuberculin testing ■ Depression screening ■ Alcohol and drug use assessment ■ Counseling to prevent sexually transmitted infections (STIs) ■ Cervical dysplasia screening ■ HIV screening ■ Blood Pressure screening ■ Tobacco use interventions 	<p>Health Counseling</p> <p>Doctors are encouraged to counsel patients about these health issues and refer them to appropriate resources as needed:</p> <ul style="list-style-type: none"> ■ Healthy diet ■ Weight loss ■ Tobacco use ■ Alcohol misuse ■ Depression ■ Prevention of STIs ■ Use of aspirin to prevent cardiovascular disease ■ Falls prevention ■ Intimate partner violence screening ■ Skin cancer behavioral health counseling <p>Immunizations</p> <ul style="list-style-type: none"> ■ Haemophilus influenzae type B ■ Hepatitis A and B ■ Herpes Zoster ■ Human Papillomavirus (HPV) ■ Influenza (Flu) ■ Measles, Mumps, Rubella ■ Meningococcal ■ Pneumococcal (pneumonia) ■ Tetanus, Diphtheria, Pertussis ■ Varicella (chicken pox) 	<p>Pregnant Women</p> <ul style="list-style-type: none"> ■ Anemia screening for iron deficiency ■ Tobacco cessation counseling ■ Syphilis screening ■ Hepatitis B screening ■ Rh incompatibility blood type testing ■ Bacteriuria urinary tract infection screening ■ Breastfeeding support, supplies, and counseling ■ Gestational diabetes screening

*The HealthSelect Plan does not impose the age limitations outlined in the current USPSTF guidelines.

ADDENDUM - RESOURCES TO HELP YOU STAY HEALTHY

What this section includes:

Health and well-being resources available to you, including:

- Personal Health Support;
- Resource Services for Specific Conditions;
- Consumer Solutions and Self-Service Tools;
- Disease and Condition Management Services; and
- Wellness Programs.

HealthSelect believes in giving you the tools you need to be an educated health care consumer. To that end, HealthSelect has made available several convenient educational and support services through UnitedHealthcare, accessible by phone and the Internet, which can help you to:

- take care of yourself and your covered Dependents;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

Notes:

Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your and your covered Dependents health. UnitedHealthcare and ERS are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the information.

The programs described in this section are “value-added” products. ERS cannot and does not guarantee the length of time that a specific type of value-added product shall be offered. Any questions or concerns about these products should be directed to UnitedHealthcare at (866) 336-9371 toll-free.

Personal Health Support

UnitedHealthcare provides a program called Personal Health Support 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 that you receive the most appropriate and Cost-Effective services available.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign 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 and identify your needs, and may also refer you to specialized care programs. The Personal Health Support Nurse will provide you with a direct telephone number so you can call with questions about your condition, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered Dependents receive appropriate medical care. Program components are subject to

change without notice. As of the publication of this MBPD, the Personal Health Support Nurse program includes:

- **Admission counseling** - For upcoming Inpatient Hospital admissions for certain conditions, a Treatment Decision Support Nurse may call you to help answer your questions and to make sure you have the information and support you need for a successful recovery.
- **Inpatient care management** - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have certain chronic or complex conditions, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- **Risk Management** - Designed for Participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the Participant's specific chronic or complex condition.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the (866) 336-9371 toll-free.

Resource Services for Specific Conditions

Cancer Resource Services (CRS)

Cancer Resource Services (CRS) offers information and assistance through a team of experienced cancer nurse consultants. These nurses are available to help Participants understand their own or a loved one's cancer diagnosis, its implications and possible treatments. They help Participants make an informed decision about their care and where to receive care. While most Participants are able to get the care they need close to home, others may benefit from being treated or getting a second opinion through UnitedHealthcare's premier cancer Centers of Excellence (COE) network. Center of Excellence is defined in Section 13, *Glossary*.

The CRS program is an ideal resource for Participants with cancer to obtain information, support and guidance in navigating the health care system. CRS nurses help Participants make informed decisions about their care and where to receive it, including access to the cancer COE network, which includes several prominent centers that otherwise would be Non-Network.

If you or a covered Dependent has cancer, you may:

- be referred to CRS by a UnitedHealthcare Personal Health Support Nurse;
- call CRS toll-free at (866) 936-6002; or
- visit www.myoptumhealthcomplexmedical.com.

To receive Benefits under the CRS program, contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper authorization to the Center of Excellence Provider performing the services.

Congenital Heart Disease (CHD) Resource Services

Congenital Heart Disease Resource Services provides extensive information to Participants to assist them in selecting a center for their care, including access to a premium Centers of Excellence (COE) network. Center of Excellence is defined in Section 13, *Glossary*.

The program also addresses condition awareness, disease and treatment education, Participant empowerment and intensive case management, when appropriate. This comprehensive set of services is provided by a team of specialized Congenital Heart Disease nurses. They provide support to Participants through all stages of treatment and recovery, to help them make informed treatment decisions and improve their health care experiences.

Specialized nurses:

- guide Participants and their families through the difficult decision-making process;
- explore alternative options to effectively address a Participant's specific diagnosis and health history;
- create Participant-specific treatment care plans driven by initial assessments and refined as needed; and
- monitor and encourage compliance with treatment plans.

Kidney Resource Services (KRS)

The Kidney Resource Services Program provides information to educate and guide Participants with chronic kidney disease and End-Stage Renal Disease (ESRD). The program provides access to a premium kidney treatment Centers of Excellence (COE) network. Center of Excellence is defined in Section 13, *Glossary*.

The program also provides a comprehensive set of services through a team of specialized renal-trained registered nurse consultants who help Participants make informed treatment decisions and improve their health care experiences. These nurses focus on improving overall health and well-being through:

- telephonic case management;
- monitoring of health and complications stemming from chronic kidney disease;
- connecting Participants with behavioral health specialists and other resources throughout treatment and recovery;
- guiding Participants to top performing, Network dialysis centers;
- efficient conversion to Medicare as primary payer to reduce unnecessary payments; and
- early referral for kidney transplant evaluation to improve Participant outcomes and reduce overall treatment costs.

You or a covered Dependent may:

- be referred to KRS by UnitedHealthcare's Personal Health Support; or
- call KRS toll-free at (888) 936-7246 and select the KRS prompt.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services for:

- vascular access placement for dialysis; or
- any ESRD services.

The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Center of Excellence Provider performing the services.

Neonatal Resource Services (NRS)

The Neonatal Resource Services program provides guided access to a network of credentialed Neonatal Intensive Care Unit (NICU) Providers and specialized nurse consulting services to manage NICU admissions to high quality Centers of Excellence facilities. Center of Excellence is defined in Section 13, *Glossary*.

These Level III Neonatal intensive care units are equipped to care for the most acute cases and have proven clinical outcomes with:

- access to a full complement of medical and surgical skills and resources;
- advanced ongoing respiratory support;
- immediate 24-hour availability of pediatric sub-specialists; and
- concentrated staffing by skilled neonatal nurses.

Note: In order to receive Benefits under this program, the Network Provider must notify NRS or UnitedHealthcare if the newborn's NICU stay is longer than the mother's Hospital Inpatient Stay.

You or a covered Dependent may also:

- call UnitedHealthcare's Personal Health Support; or
- call NRS toll-free at (888) 936-7246 and select the NRS prompt.

Other Resource Services

UnitedHealthcare's resource services are also available if you are undergoing bariatric surgery. See *Bariatric Surgery* in Section 6, *Details for Covered Health Services*.

UnitedHealthcare's resource services are also available if you are undergoing an organ or tissue transplant. See *Transplant Services* in Section 6, *Details for Covered Health Services*.

Consumer Solutions and Self-Service Tools

Health Assessment

You and your Dependents are invited to learn more about your health and wellness at www.myuhc.com/hs and are encouraged to participate in the online health assessment. The health assessment is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health assessment is kept confidential. Completing the assessment will not impact your Benefits or eligibility for Benefits in any way. The results of the health assessment are not shared with your Employer or ERS.

To find the health assessment, log in to www.myuhc.com/hs. After logging in, access your personalized *Health & Wellness* page and click the *Health Assessment* link. If you need any assistance with the online assessment, please call (866) 336-9371 toll-free.

Health Improvement Plan

You can start a Health Improvement Plan at any time. This plan is created just for you and includes information and interactive tools, plus online health coaching recommendations based on your profile.

Online coaching is available for:

- nutrition;
- exercise;
- weight management;
- stress;
- tobacco cessation;
- diabetes; and
- heart health.

To help keep you on track with your Health Improvement Plan and online coaching, you'll also receive personalized messages and reminders – UnitedHealthcare's way of helping you meet your health and wellness goals.

NurseLineSM

NurseLine is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week, 365 days a year.

UnitedHealthcare Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that HealthSelect has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take prescription drugs safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLine gives you another convenient way to access health information. By calling the same toll-free number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half available in Spanish.

NurseLine is available to you at no cost. To use this convenient service, simply call (866) 336-9371 toll-free.

Your child is running a fever and it's 1:00 AM. What do you do?
Call NurseLine toll-free, any time, 24 hours a day, seven days a week, 365 days a year. You can count on NurseLine to help answer your health questions.

With NurseLine, you also have access to nurses online. To use this service, log onto www.myuhc.com/hs and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Note: If you have a medical Emergency, call 911 instead of calling NurseLine.

Reminder Programs

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

- mammograms for women between the ages of 40 and 68;
- pediatric and adolescent immunizations;
- cervical cancer screenings for women between the ages of 20 and 64;
- comprehensive screenings for Participants with diabetes; and
- influenza/pneumonia immunizations for Participants age 65 and older.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

Treatment Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Treatment Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care;
- expectations of treatment; and
- information on high quality Providers and programs.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer;

- coronary disease and
- bariatric surgery.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact (866) 336-9371 toll-free.

UnitedHealth PremiumSM Program

UnitedHealthcare designates Network Physicians as UnitedHealth PremiumSM Program Physicians for certain medical conditions. Physicians are evaluated on two levels - quality and efficiency of care. The UnitedHealth PremiumSM Program was designed to:

- help you make informed decisions on where to receive care;
- provide you with decision support resources; and
- give you access to Physicians across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria.

For details on the UnitedHealth PremiumSM Program, including how to locate a UnitedHealth PremiumSM Physician, log onto **www.healthselectoftexas.com** or call (866) 336-9371 toll-free.

www.myuhc.com/hs

UnitedHealthcare's dedicated website for HealthSelect Participants, **www.myuhc.com/hs**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com/hs** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com/hs** you can:

- receive personalized messages that are posted to your own website;
- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for Network Providers available in your Plan through the online Provider directory;
- access all of the content and wellness topics from NurseLine including Live Nurse Chat 24 hours a day, seven days a week, 365 days a year;
- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Note: ERS will work with UnitedHealthcare to provide additional online tools in the future such as the treatment cost estimator that will give you an estimate of the costs for various health-related procedures in your area.

Registering on www.myuhc.com/hs

If you have not already registered as a **www.myuhc.com/hs** subscriber, simply go to **www.myuhc.com/hs** and click on "Register Now." Have your HealthSelect medical ID card handy. The enrollment process is quick and easy.

Visit www.myuhc.com/hs and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including, but not limited to, Copays and Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement HealthSelect medical ID card or print a temporary ID card.

Want to learn more about a condition or treatment?

Log on to www.myuhc.com/hs and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Provider.

Disease and Condition Management Services

Cancer Support Program

UnitedHealthcare provides a program that identifies, assesses, and supports Participants who have cancer. The program is designed to support you. This means that you may be called by a registered nurse who is a specialist in cancer and receive free educational information through the mail. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to advise you and to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer education on cancer, and self-care strategies and support in choosing treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call (866) 336-9371 toll-free or call the program directly at (866) 936-6002.

For information regarding specific Benefits for other cancer resource services, see *Resource Services for Specific Conditions* in this Addendum under the heading *Cancer Resource Services (CRS)*.

Disease Management Services

If you have been diagnosed with or are at risk for developing certain chronic medical conditions, you may be eligible to participate in a disease management program at no cost to you. The heart failure, coronary artery disease, diabetes and asthma programs are designed to support you. This means that you will receive free educational information through the mail, and may be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;
- access to educational and self-management resources on a consumer website;
- an opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care; and
- toll-free access to one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:

- education about the specific disease and condition,
- medication management and compliance,
- reinforcement of on-line behavior modification program goals,
- preparation and support for upcoming Physician visits,
- review of psychosocial services and community resources,
- caregiver status and in-home safety,
- use of mail-order pharmacy and Network Providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact (866) 336-9371 toll-free.

HealthNotesSM

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

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process Participants are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 13, *Glossary*, under the definition of Covered Health Services.

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

If you have questions or would like additional information about this service, please call (866) 336-9371 toll-free.

Wellness Programs

Wellness Coaching

UnitedHealthcare offers a personalized Wellness Coaching program that can help you identify health risks, set goals and develop personalized strategies that empower you to make positive lifestyle changes to help improve your health and well-being. Our one-on-one coaching program integrates phone- and mail-based communications with an online interactive health coach on www.myuhc.com/hs.

The Wellness Coaching program gives you access to specially trained personal wellness coaches to get you started and provides support that can keep you on track. Our certified wellness coaches are cross-trained in multiple wellness concentrations for a more complete coaching experience. You will be assigned one wellness coach at the onset of your program and will be guided by the same coach throughout the program. Through information sharing, the wellness coach will work with you to create a personalized action plan that evolves throughout the program.

Wellness Coaching supports individuals with the following lifestyle issues:

- diabetes;

- exercise;
- heart health;
- nutrition;
- stress management;
- tobacco cessation; and
- weight management.

This program is offered at no cost to you or your Dependents. To enroll in the program, call Wellness Coaching toll-free at (800) 478-1057.

Healthy Pregnancy Program

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling (866) 336-9371 toll-free. This program offers:

- Pregnancy consultation to identify special needs;
- written and on-line educational materials and resources;
- 24-hour toll-free access to experienced maternity nurses;
- a phone call from a care coordinator during your Pregnancy, to see how things are going; and
- a phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call (866) 336-9371 toll-free.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

ADDENDUM - UNITEDHEALTH ALLIES

Introduction

This Addendum to the Master Benefit Plan Document provides discounts for specific non-Covered Health Services from Physicians and health care professionals.

When the words "you" and "your" are used, the Plan is referring to Participants as the term is defined in the MBPD. See Section 13, *Glossary*, in the MBPD.

Important:

UnitedHealth Allies is not a health insurance plan. You are responsible for the full cost of any services purchased, minus the applicable discount. Always use your health insurance plan for Covered Health Services described in the MBPD (see Section 5, *Schedule of Benefits and Coverage*) when a Benefit is available.

What is UnitedHealth Allies?

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

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through UnitedHealth Allies are available to you and your covered Dependents as defined in the MBPD in Section 13, *Glossary*.

Selecting a Discounted Product or Service

A list of available discounted products or services can be viewed online at www.healthallies.com or by calling (866) 336-9371 toll-free.

After selecting a health care professional and product or service, reserve the preferred rate and print the rate confirmation letter. If you have reserved a product or service with a customer service representative, the rate confirmation letter will be faxed or mailed to you.

Important:

You must present the rate confirmation at the time of receiving the product or service in order to receive the discount.

Visiting Your Selected Health Care Professional

After reserving a preferred rate, make an appointment directly with the health care professional. Your appointment must be within 90 days of the date on your rate confirmation letter.

Present the rate confirmation and your HealthSelect medical ID card at the time you receive the service. You will be required to pay the preferred rate directly to the health care professional at the time the service is received.

Additional UnitedHealth Allies Information

Additional information on the UnitedHealth Allies program can be obtained online at www.healthallies.com or by calling UnitedHealthcare at (866) 336-9371 toll-free.

Note: UnitedHealth Allies is a “value-added” product. ERS cannot and does not guarantee the length of time that a specific type of value-added product shall be offered. Any questions or concerns about these products should be directed to UnitedHealthcare at (866) 336-9371 toll-free.

ADDENDUM - PARENTSTEPS®

Introduction

This Addendum to the Master Benefit Plan Document illustrates the benefits you may be eligible for under the ParentSteps program.

When the words "you" and "your" are used, the Plan is referring to Participants as the term is defined in the MBPD. See Section 13, *Glossary*, in the MBPD.

Important:

ParentSteps is not a health insurance plan. You are responsible for the full cost of any services purchased. ParentSteps will collect the Provider payment from you online via the ParentSteps website and forward the payment to the Provider on your behalf. Always use your health coverage plan for Covered Health Services described in the MBPD in Section 5, *Schedule of Benefits and Coverage*, and Section 6, *Details for Covered Health Services*, when a Benefit is available.

What is ParentSteps?

ParentSteps is a discount program that offers savings on certain medications and services for the treatment of infertility that are not Covered Health Services under the Plan.

This program also offers:

- guidance to help you make informed decisions on where to receive care;
- education and support resources through experienced infertility nurses;
- access to Providers contracted with UnitedHealthcare that offer discounts for infertility medical services; and
- discounts on select medications when filled through a designated pharmacy partner.

Because this is not a health insurance plan, you are not required to obtain a referral or submit any claim forms.

Discounts through this program are available to you and your eligible Dependents. Dependents are defined in the MBPD in Section 13, *Glossary*.

Registering for ParentSteps

Prior to obtaining discounts on infertility medical treatment or speaking with an infertility nurse, you need to register for the program online at www.myoptumhealthparentsteps.com or by calling ParentSteps toll-free at (877) 801-3507.

Selecting a Contracted Provider

After registering for the program you can view ParentSteps facilities and clinics online based on location, compare in vitro fertilization (IVF) cycle outcome data for each participating Provider and see the specific rates negotiated by ParentSteps with each Provider for select types of infertility treatment in order to make an informed decision.

Visiting Your Selected Health Care Professional

Once you have selected a Provider, you will be asked to choose that clinic for a consultation. You should then call and make an appointment with that clinic and mention you are a ParentSteps member. ParentSteps will validate your choice and send a validation email to you and the clinic.

Obtaining a Discount

If you and your Provider choose a treatment in which ParentSteps discounts apply, the Provider will enter in your proposed course of treatment. ParentSteps will alert you, via email, that treatment has been assigned. Once you log in to the ParentSteps website, you will see your treatment plan with a cost breakdown for your review.

After reviewing the treatment plan and determining it is correct you can pay for the treatment online. Once this payment has been made successfully, ParentSteps will notify your Provider with a statement saying that treatments may begin.

Speaking with a Nurse

Once you have successfully registered for the ParentSteps program you may receive additional educational and support resources through an experienced infertility nurse. You may work with an individual nurse throughout your treatment if you choose.

For questions about diagnosis, treatment options, your plan of care or general support, please contact a ParentSteps nurse by calling (866) 774-4626 toll-free.

ParentSteps nurses are available from 8 a.m. to 5 p.m. Central Time; Monday through Friday, excluding holidays.

Additional ParentSteps Information

Additional information on the ParentSteps program can be obtained online at www.myoptumhealthparentsteps.com or by calling (877) 801-3507 (toll-free).

Note: ParentSteps is a “value-added” product. ERS cannot and does not guarantee the length of time that a specific type of value-added product shall be offered. Any questions or concerns about these products should be directed to UnitedHealthcare at (866) 336-9371 toll-free.

